# FOR STATE HEALTH DEPT.

TO DEPUTY C. EXAMINER: This certificate should be executed within 24 hours after if, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a buriel-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. 0

VS. A15ME 5M 7/59

#### MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH 06601

•	1. PLACE OF DEATH  e. COUNTY	2. USUAL RESIDENCE (Where decessed lived, If institution; Res	sidence before edmission)					
	Carroll	a. STATE Maryland b. COUNTY Bal	to_City					
	b. CITY OR TOWN (if outside corporete limits, write RURAL end give necrest town)	c. CITY OR TOWN (If outside corporete limits, write RURAL end	give neerest town)					
	Sykesville 3yrs.12days	Baltimore 31 3V01	-4-					
5	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)	d. STREET ADDRESS	IS RESIDENCE     ON A FARM?					
	Springfield State Hospital	23 S. Duncan Street	YES NO DE					
	3. NAME OF First Middle DECEASED		Day Year					
		Beck DEATH June	15. 1961					
10	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8	DATE OF BIRTH 9. AGE (In yeers   IF UNDER 1 Y						
1	Female White widowed Divorced S	September 6, 1904 56 yrs. Months De	ys Hours Min.					
ŀ	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	Y 11. BIRTHPLACE (State or foreign country) 12. CITIZE	N OF WHAT COUNTRY?					
	Housewife -	Maryland U.	S.A.					
	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME						
	George Edw. Pearman	Magdalena Sparr						
	15. WAS DECEASED EYER IN U.S. ARMED FORCES?   16. SOCIAL SECURITY NO. 17. I	NFORMANT Address						
		pringfield Hospital Records						
	18. CAUSE OF DEATH  Enter only one cause per line for (e), (b), end (c).]		INTERVAL BETWEEN ONSET AND DEATH					
	PART I. DEATH WAS CAUSED 8Y: IMMEDIATE CAUSE (6) Decompensatory he	24 hours.						
	4/22,/ DUE TO							
	Conditions, if eny, which \ (b) Arteriosclerotic	cardiovalvular disease	Years					
	geve rise to immediate cause (a), stating the underlying DUE TO							
	cause lest. (c) Generalized arter		Years					
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO C. B.S. assoc. with convulsive disorder w.	T RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1	e) 19. WAS AUTOPSY PERFORMED?					
	S Obesity.	run paychoute reacuton.	YES X NO					
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO C. B. S. assoc. with convulsive disorder w.  Obesity.  200. EXTERNAL CAUSE WAS PRIMARY   or CONTRIBUTING   2Db. DESCRIBE HOW INJURY OCCURED. (E. CAUSE OF DEATH.	20e. EXTERNAL CAUSE WAS   2Db. DESCRIBE HOW INJURY OCCURED. (Enter neture of Injury in Pert I or Pert II of item 18.)						
	Supplied the supplied to the s	CE OF INJURY (Home, ferm, 20f. (City or town) (Country, street, office bldg., etc.)	y) (State)					
		spital Baltimore City	Maryland					
	21. I certify that I took charge of the remains described above, he	d an Autopsy X, Inspection X, Inquiry X,	and in my opinion					
	death resulted from: Natural causes 🔼, Accident 🔲, Suici	ide, Homicide, Undetermined manner						
	1 1 9 9 11	CHIEF MEDICAL EXAMINER						
7	SIGNATURE GLEEN . March	M.D. ASSISTANT MEDICAL EXAMINER	DATE SIGNED					
4	EXAMINER'S	DEPUTY MEDICAL EXAMINER	6/15/61					
	Name (1961) James T. Marsh, M.D.	Address (Street, City, Town, or County)						
	22e. SURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR REMOVAL (Specify)	CREMATORY 22d. LOCATION (City, town, or country)	(State)					
	BURIAL JUNE 19,1961 HOLY REDEEN							
	23. FUNERAL DIRECTOR ADDRESS  ADDRESS  ADDRESS  ADDRESS	246. REC'D 8Y REGISTRAR   24b. REGISTRAR'S SIG						
-	HENRY SANDER & SONS INC. BALTIMORE	E MD. DATE AIN 19'61 Chilun S.	Tiraus					

CONTRACTOR OF STATE OF SAME AND STAGE There I was the first of the state of the st there's name to be a second of the many of the latest the second of the As a Shundren to all virtues - 1 emiffed asserting temperature and THE MENT OF THE PARTY AND THE PARTY NAMED IN medical relations and the state of the state enstread with smeather the formula to the first and the second of the second The second secon SERVICE TO THE WELL AND THE REPORT OF SOME THE RESIDENCE OF THE PERSON.

#### MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS -- BALTIMORE 1, MARYLAND

	6618 CERTIFICATE OF	F DEATH 06602	
M	PLACE OF DEATH O. COUNTY Carroll MARYLAND 2. USUA O. STA	AL RESIDENCE (Where deceased lived. If institution: Residence before admission)  ATE  Maryland  b. COUNTY  City	/
	b. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest tawn)  Sykesville  Lyr.llmos.2days	TY OR TOWN (If autside carporate limits, write RURAL and give nearest town)  Baltimore 31	- 4
15	d. NAME OF HOSPITAL (If not in hospital, give street oddress) OR INSTITUTION Springfield State Hospital	FREET ADDRESS  8. IS RESIDENON A FARRY YES NO	M?
	NAME OF First Middle DECEASED (Type or print) Esther Madison	Bell 4. DATE Month Day Yeor Per June 9, 196	
		il 3, 1887   lost birthdoy)   Months   Doys   Hours   M	Ain.
	0o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  Housewife  - 10b. KIND OF BUSINESS OR INDUSTRY 11. B	New York U.S.A.	ITRY?
(I)	William Madison Mount	Rachael Dafter	
	5. WAS DECEASED EVER IN U. S. ARMED FORCES?  Yes, no. or unknown)  If yes, give wor or dates of service)  S  S  S  S  S  S  S  S  S  S  S  S  S	pringfield Hospital Records	
	PART I. DEATH [Enter only one cause per line for (a), (b), ond (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Canditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last.  (b)  Rheumatic heart diseas  DUE TO  (c)	50.	(TH
		ATED TO THE TERMINAL DISEASE CONDITION (COVERNIN PART 1(a) 19. WAS AUTO PERFORMED YES IN NO.	D?
7	200. ACCIDENT WAS UNDERLYING   OR CONTRIBUTING   CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED Haur a. m. 19 While of work of wark 20e. PLACE OF IN factory, stree	et, affice bldg., etc.)	State)
	21. I certify that (I) (this haspital) attended the deceased fram July saw the deceased alive an June 9, 1961, and that death ac	7, 1959, to June 9, 1961, that (I) (we) coursed a 2:204 M ram the causes and an the date stated about	last ave.
1	The PHYSICIAN'S	rending Med. STAFF 6/9/6  Address Springfield Hospital, Sykesville, Md.	TE NED
	23c. NAME OF CEMETERY OR CREMAT REMOVAL (Specify)  ( 7 2 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0		
of a	Assalm Finned Home 7401 Blan Rd	250. REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE  DATEUN 1 3 '61 CIVILIN S. Trans	2

E133 Tyre, TImon, Zdasu and the state of the and the son and a strong of the sayer la land Conditionary of selecting off or absorbered resident transfer of the selection of the selec es and the state of the state o The same of the sa THE PERSON AND PERSON NAMED IN City commodels nitowns. weeks mant their Tree Steel

301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased fived, If institution: Residence before edmission) b. COUNTY Carroll Maryland Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give neerest lown) Rural --- Sykesville e. IS RESIDENCE ON A FARM? YES NO Obrecht Road 4. DATE Month Year OF DEATH 19 61 June AGE (In yeers | IF UNDER 1 YEAR IF UNDER 24 HRS. B. DATE OF BIRTH lest birthdey) Months Hours yrs. 12. CITIZEN OF WHAT COUNTRY? Carroll Co. Md. U. S. A. Elizabeth Shipley Mr. Ralph M. Bennett, Sykesville, Md. INTERVAL BETWEEN ONSET AND DEATH PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) PERFORMED? NO T 20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Pert 1 or Pert II of item 18.) 20e. PLACE OF INJURY (Home, ferm, 20f. (City or town) (Stete) fectory, street, office bldg., etc.) ext., 1961, that (I) (we) last 21. certify that (1) (this hospital) attended the deceased from.... 22b. DATE ATTENDING SIGNED MED STAFF DIRECTOR PHYS. PHYS. 22d. ADDRESS

papers. Pages I filled ir Pages completely carbon physician and please 2 aftending and removal, signed by the physicia burial-transit aftending has been TOR: After this certificate Ses use prior detached for Health death. Page TO FUNERAL director, page 3 be filed with th VR A15 (4) 15M 9/60

the d 2

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and

24 FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz.

200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

saw the deceased alive on...

23e. BURIAL, CREMATION, | 23b. DATE THEREOF

Month, Dey, Year

20c. TIME OF INJURY

22e. SIGNATURE

22c. PHYSICIAN'S

REMOVAL (Specify)

NAME (Type)

Winfield, Maryland

20d. INJURY OCCURRED

et work et work

While

Howard E. Hall, M. D.

1961

Not While

23c. NAME OF CEMETERY OR CREMATORY

Wesley Cemetery

Carroll Co., Maryland 250. REC'D BY REGISTRAR | 256. REGISTRAR'S SIGNATURE JUN 1 4 '61

DATE

Sykesville, Maryland

23d. LOCATION (City, town or county)

arthur & Kraus

(Stete)

Spinsaville John F. Mentert Eury of 5-18, 1951 Washer Canadary Canadal Co., Maryland

Trees D. hastyralf SELECTION OF THE PROPERTY OF T

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Mosmed M. Markey Markey Markey Maryland

CT I. Majers, Winite and Barriand of the State of the Sta

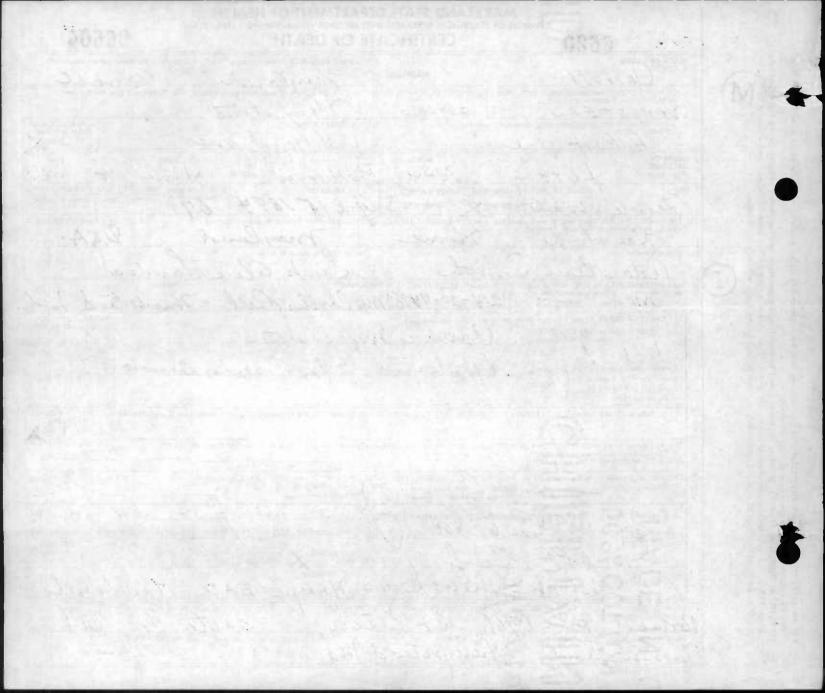
## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06604

0.020	CERTITION	AIL OI DAAIII	9	0001
1. PLACE OF DEATH o. COUNTY	MARYLAND	2. USUAL RESIDENCE (Where deceased lived a. STATE	b. COUNTY	e befare admission)
b. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest tawn)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If autside carporate li	mits, write RURAL and gi	ive nearest tawn)
d. NAME OF HOSPITAL (If not in hospital, give street of OR INSTITUTION	20910-3	d. STREET ADDRESS	es	e. IS RESIDENCE ON A FARM? YES NO
3. NAME OF DECEASED (Type or print) LO++1C	MAH	Bollinger 4. DATE OF DEATH	Vane	Day Year 96/
S. SEX 6. COLOR OR RACE 7. MARRIE	D NEVER MARRIED DIVORCED	B. DATE OF BIRTH  Cyril 15 1894  9. AC	70010	YEAR IF UNDER 24 HRS Days Haurs Min.
10a. USUAL OCCUPATION (Give kind af work dane 10b. K during mast of warking life, even if retired)	DO OF BUSINESS OR INC	DUSTRY 11. BIRTHPLACE (State or foreign country	12.CITIZ	EN OF WHAT COUNTRY
13. FATHER'S NAME	ich	14. MOTHER'S MAIDEN NAME	Lander	
(Yes, no, or unknown) (If yes, give war or dates of service)	4-20-7498	my Phyllis Rill	Harufal	God med
1B. CAUSE OF DEATH [Enter only one cause per line PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	for (a), (b), and (c).]	my readetis	9	INTERVAL BETWEEN ONSET AND DEATH
Canditians, if any, which gave rise to immediate cause (a), stating the <u>under-lying</u> cause last.	ypes leveres	e Culio Vascular	Lessin	7
PART II. OTHER SIGNIFICANT CONDITIONS	INTRIBUTING TO DEATH B	UT NOT RELATED TO THE TERMINAL DISEASE COR	NDITION GIVEN IN PART	1(a) 19. WAS AUTOPSY PERFORMED? YES NO
20b. DESCI OR CONTRIBUTING — CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	IBE HOW INJURY OCCUR	RED. (Enter nature of injury in Part I or Part II of	item 18.)	-
Haur a.m. While	JURY OCCURRED 20e. Nat while at work	PLACE OF INJURY (Hame, form, factory, street, affice bldg., etc.)	(C	ounty) (State
21. 1 certify that (1) (this haspital) attended saw the deceased alive an according to	/	n fisse 3 1960, to the death accurred at LUAM, from the		, that (I) (we) las
22a. SIGNATURE	col ·	M.D. PHYS. DIRECTOR PH	AFF IYS.	22b. DATE SIGNE
NAME (Type) Joseph E.	BusLA	10 HAMPSTEAD	Mary	land
230 BURIAL CREMATION, 23b. DATE THEREOF SECULAR 10/61	23c. NAME OF CEMETERY	OR CREMATORY 23d. LOCATION	(City, tawn, ar county)	What (State)
24 FUNERAL DIRECTOR'S SIGNATURE	ADDRESS acceptates	250. REC'D BY REGISTRAR DATEUN 1 3 '61	25b. REGISTRAR'S SIG	

TO HOSPITAL OR VR A1S (4) 1SM 9/59



ieral director, be fitted with

Page 4

VR A15 (4) 1SM 9/59

### MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06605

(	5621		CERTIFICA	ATE OF DEAT	H		-100	0000	15
1. PLACE OF DEATH a. COUNTY Carrell			MARYLAND	2. USUAL RESIDENCE ( a. STATE Marylan		b. COUNTY	on: Residence	e befare adn	nission)
		its, write	c. LENGTH OF STAY IN 16	++	If autside corpo	rote limits, write RU	JRAL ond gi	ive nearest to	- 4.
d. NAME OF HOSPI OR INSTITUTION	TAL (If nat in hospital,			d. STREET ADDRESS			- 11	10	RESIDENCE
	State Hos	-		1204 Mc		Street		YES	□ NO 💆
3. NAME OF DECEASED (Type or print)	Je	ohn.	Middle <b>Thomas</b>	Bowie	4. DATE OF DEATH	Jur	le .	22,	19 <b>61</b>
S. SEX	6. COLOR OR RACE	7. MARRI	ED NEVER MARRIED	B. DATE OF BIRTH		9. AGE (In years last birthdoy)		Days Hou	NDER 24 HRS
Male	Negro	WIDOWE	DIVORCED [	6-19-1900		61 yrs.	Months	Days	15 194111.
Truck Dr	rking life, even if retired	dane 10b. K	IND OF BUSINESS OR IND	Montgome	ery Co.	1807		J.S.A.	T COUNTRY?
13. FATHER'S NAME				14. MOTHER'S MAIDE	N NAME				
Charles	McAber			Nannie 1	Bowie	- 31 6			
IS. WAS DECEASED EV	ER IN U. S. ARMED FOI		OCIAL SECURITY NO. 17.	INFORMANT		Addr	ess		
No	(it yes, give war or dates or		16-10-6938	John Thomas	s Bowie	- Patie	ent		
18. CAUSE OF DE	ATH [Enter anly one co	ouse per line	far (a), (b), and (c).]					INTERVAL	BETWEEN
	ATH WAS CAUSED BY:			llat. cavita	mre mule	******* +1	ha	ONSET A	ND DEATH
AAG	2 1		advanced b.	LIAL. VAVICA	Ty pari	nonal y c	00.		
00.	DUE TO								
Conditions, if		0)						1	
cause (o), stating									
lying couse last		c)							
PART II. O1	THER SIGNIFICANT COM	IDITIONS C	ONTRIBUTING TO DEATH B	UT NOT RELATED TO THE TE	RMINAL DISEAS	E CONDITION GIV	EN IN PART	PER	AS AUTOPSY RFORMED?
20a. ACCIDENT W OR CONTRIBUTING (IF EITHER, NOTIF	AS UNDERLYING  G CAUSE OF DEATH Y MEDICAL EXAMINER)	20b. DESC	RIBE HOW INJURY OCCUR	RED. (Enter noture of injury	in Port I or Por	1 11 of item 1B.)			
ZOc. TIME OF INJU Hour a.m. p. m.	RY Month, Day, Ye	20d, IN While ot work	Nat while	PLACE OF INJURY (Home, f foctory, street, office bldg.,		r ar tawn)	(C	ounty)	(Stote)
21. I certify the	at (I) (this haspita	l) attende 1e 22	ed the deceased from		1961 ta 10 a m	June 22, the causes an	19 <b>61</b> d an the	_, that (I	) (we) last ed abave
220. SIGNATURE	odgars m	. ma	enlary	M.D. ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.			226. DATE 225. CATE
22c. PHYSICIAN'S NAME (Type)	Edgars M.	Macu	Lans, Supt.	Henryton	n State	Hospita	1, Не	enryte	n, Md
23a. BURIAL, CREMATI REMOVAL (Specify	ON. 23b. DATE THERE	7/6/	23c. NAME OF CEMETERY	OR CREMATORY Comments	23d. LOCA	TION (City, town, o	re	city	Stote)
24. FUNERAL DIRECTO	R'S SIGNATURE	1	ADDRESS		EC'D BY REGIS	TRAR 25b. REGIS	STRAR'S SIG	NATUR	
morto	2 KD	Ye	elp 716/	Pen Ex DATE	JUN 2 8	'61 a	Min 9	House	

20939 a design in errowit Lo-Look Negation (Spice) The state of the s - -Managerus Miller , Miller T. H. el mi el mu Maintel of the Change Change to the Contract TO SEE A SECOND OF THE SECOND ... Marcha M. Bugulline, Sant, be effected bees the sufficient, Monroen, 186. V = 300 200 200 200 200

#### MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH 6699

06606

1. PLACE OF DEATH						~~~
o. COUNTY Carroll	MARYLAND	2. USUAL RESIDENCE (Woo. STATE		d. If institution b. COUNTY	on: Residence bei	
b. CITY OR TOWN (If outside corporate limits, wring RURAL and give nearest town)  Sykesville	ite c. LENGTH OF STAY IN 16  Lyr. 3mos. 25da	c. CITY OR TOWN (If	outside corporate		JRAL ond give n	earest fown)
d. NAME OF HOSPITAL (If not in hospital, give strong institution  Springfield State Hos		d. STREET ADDRESS	<u>er Sprin</u> Dartmoutl			e. IS RESIDENC ON A FARM YES NO
3. NAME OF First	Middle Rebecca Barkley	Brown	4. DATE OF DEATH	Moni Jun	- 1	Day Year
S. SEX 6. COLOR OR RACE 7. N	MARRIED NEVER MARRIED DIVORCED	8. DATE OF BIRTH July 16, 18	9. A	GE (In years st birthday)		AR IF UNDER 24 H
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDU	ISTRY 11. BIRTHPLACE (Stote		y)	12. CITIZEN	OF WHAT COUNT
3. FATHER'S NAME Archibald Barkley		14. MOTHER'S MAIDEN	NAME ret Micha	el		
IS. WAS DECEASED EVER IN U. S. ARMED FORCES?  (Yes, no or unknown)  (If yes, give wor or dates of service)		NFORMANT Springfield H		Addr		000
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Conditions, if any, which gave rise to immediate couse (a), stoting the under. lying cause lost.  C. B. S. ASSOC. WILL CITY	Bronchopneumoni		what disease co	NDITION GIV		19. WAS AUTOP PERFORMED
						1 110
OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  20c. TIME OF INJURY Month, Day, Year Hour a.m.		ED. (Enter noture of injury in LACE OF INJURY (Hame, far actory, street, office bldg., et	m, 20f. (City ar t		(Count	
	od. INJURY OCCURRED 20e. Pt. fo work at work tended the deceosed from 5,19_61 and that a	February10, 19 death occurred at 12	m, 20f. (City or to 1) 20f. to Jux  20f. to Jux  20f. PMm the	couses an	, 19 <u>.61</u> , d on the da	that (I) (we) I te stated abo 22b. DATI 6/5/61Gh
20c. TIME OF INJURY Month, Day, Year 20 Hour a.m. p. m. 19 ot  21. I certify that (I) (this hospital) att sow the deceased alive on June 22a. SIGNATURE  22c. PHYSICARS	od. INJURY OCCURRED  thile work at work tended the deceosed from.  5,19_61 and that at the december of the	ACE OF INJURY (Hame, for cotory, street, office bldg., et learning to the cotory). The cotory of the	m, 20f. (City or to 1) 20f. to Jux  20f. to Jux  20f. PMm the	couses an TAFF THYS. TO (Gity, tawn, constant)	19_61, d on the da /kesvill	that (I) (we) I the stated about the sta

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remave carbon pages 1 and 2 shauld be filed with the State Boord of Health priar to burial, cremation, ar remaval, and in any event, within 72 haurs after death. DING PHYSICIAN: The low requires that the death certificate be executed ospital ar ottending physician. TO HOSPITAL OF

VR A1S (4) 1SM 9/S9

Page 4

Sulfationary Co., St. Co., St. St. Will drawstall ITA The state of the s LINGTH WEEK Leen, ml fred the state of the state of MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

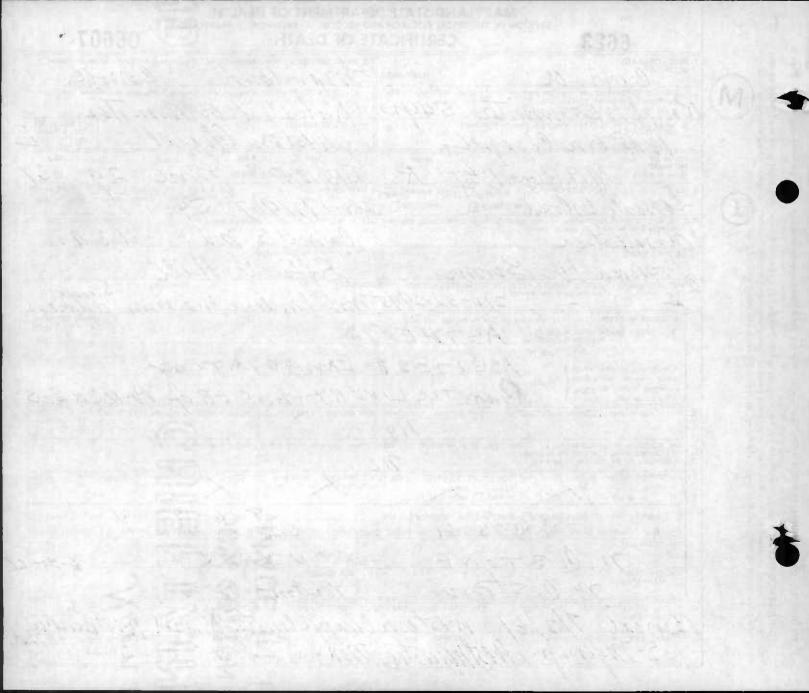
CERTIFICATE OF DEATH

06607

	1	4	3
ofter d. Poge 4	the funeral director,	2 shauld be filed with	M
be executed y 24 hours	and completely filled in by	rbon papers. Poges I and 772 hour affer death.	I)
es that the death certificate l	ed by the attending physician	mit. Then please remave car aval, and in any event, within	
PHYSICIAN: The low require	tal ar ottending physician. this certificate has been signe	or use as the burial-transit per r ta burial, cremation, or rema	0
TO HOSPITAL OF TANDING PHYSICIAN: The low requires that the death certificate be executed y 24 hours offer d n. Poge 4	may be retained cospital or ottending physician.  TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,	page 3 should be detached for use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 2 shauld be filed with the State Board of Health prior to burial, cremation, or remaval, and in any event, within 72 hours after death.	
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VR A15 (4) 15M 9/59

	6623	CERTIFICA	TE OF DEATH		06607
			2. USUAL RESIDENCE (Where dec		esidence befare admission)
	a. COUNTY CANTOLL	MARYLAND	marrian	b. COUNTY	anoll
	b CITY OR TOWN (If autside carporate limits, write c.	LENGTH OF STAY IN 16	c. CITY OR TOWN (If autside of	carporate limits, write RURAL	and give nearest tawn)
1	mail West numerica	5440	Kunal.	Westun	uster
-	d. NAME OF HOSPITAL (If not in haspital, give street add	ress)	d. STREET ADDRESS	00	e. IS RESIDENCE ON A FARM?
	PLACE OF DEATH  a. COUNTY  MARYLAND  b. CITY OR TOWN (If outside corporale limits, write RURAL and give pearest town b. COUNTY  A. NAME OF ROSPITAL (If not in incipilal, give street address)  A. NAME OF ROSPITAL (If not in incipilal, give street address)  A. NAME OF ROSPITAL (If not in incipilal, give street address)  A. NAME OF DECEASED  A. DATE  OF BIRTH  A. DATE  OF BIRTH  A. AGE (In years   If FUNDER   Incipilal)  B. COLOR OR RACE   7. MARRIED   NEVER MARRIED   PATE OF BIRTH  DIVIDING   Incipilal   In	YES NO			
3.	PLACE OF DEATH  a. COUNTY  MARYLAND  B_CITY OR TOWN If outside carporote limits, write   C. LENGTH OF STAY IN 16   C. CUTY OR TOWN If outside carporote limits, write   C. LENGTH OF STAY IN 16   C. CITY OR TOWN If outside carporote limits, write   C. LENGTH OF STAY IN 16   C. CITY OR TOWN If outside carporote limits, write   C. LENGTH OF STAY IN 16   C. CITY OR TOWN If outside carporote limits, write   C. LENGTH OF STAY IN 16   C. CITY OR TOWN If outside carporote limits, write   C. LENGTH OF STAY IN 16   C. CITY OR TOWN If outside carporote limits, write   C. LENGTH OF STAY IN 16   C. CITY OR TOWN If outside carporote limits, write   C. LENGTH OF STAY IN 16   C. CITY OR TOWN If outside carporote limits, write   C. LENGTH OF STAY IN 16   C. CITY OR TOWN If outside carporote limits, write   C. LENGTH OF STAY IN 16   C. CITY OR TOWN If outside carporote limits, write   C. LENGTH OF STAY IN 16   C. CITY OR TOWN If outside carporote limits, write   C. LENGTH OF STAY IN 16   C. CITY OR TOWN If outside carporote limits, write   C. LENGTH OF STAY IN 16   C. CITY OR TOWN If outside carporote limits, write   C. LENGTH OF STAY IN 16   C. CITY OR TOWN If outside carporote limits, write   C. LENGTH OF STAY IN 16   C. CITY OR TOWN If outside carporote limits, write   C. LENGTH OF STAY IN 16   C. CITY OR TOWN If outside carporote limits, write   C. LENGTH OF STAY IN 16   C. CITY OR TOWN If outside carporote limits, write   C. LENGTH OF STAY IN 16   C. CITY OR TOWN If outside   C. CITY OR TOWN If outside   C. LENGTH OF STAY IN 16   C. CITY OR TOWN If outside   C. LENGTH OF STAY IN 16   C. CITY OR TOWN If outside   C. LENGTH OF STAY IN 16   C. CITY OR TOWN If outside   C. LENGTH OF STAY IN 16   C. CITY OR TOWN If outside   C. LENGTH OF STAY IN 16   C. CITY OR TOWN If outside   C. LENGTH OF STAY IN 16   C. CITY OR TOWN If outside   C. LENGTH OF STAY IN 16   C. CITY OR TOWN If outside   C. LENGTH OF STAY IN 16   C. CITY OR TOWN If outside   C. LENGTH OF STAY IN 16   C. CITY OR TOWN If outside   C. LENGTH OF STAY IN 16   C. CITY O	Day Year			
		FT R			29 1961
5. 5	6. COLOR OR RACE 7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH		NDER 1 YEAR IF UNDER 24 HRS.
J	Almale Colored WIDOWED [	DIVORCED [	tel-17,190		nths Days Haurs Min.
100	USUAL OCCUPATION (Give kind of wark done 10b. KIN	D OF BUSINESS OR INDU	STRY 11. BIRTHPLACE (State or fale)	ign country)	2. CITIZEN OF WHAT COUNTRY?
	america		Carroll Co.	md.	U.S.a.
13.	FATHER'S NAME		14. MOTHER'S MAIDEN NAME	11 11 00	
	Johna W. Brown	m	Still L	1. Hell	
1%	WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOC s, no, or unknown) (If yes, give wor or dates of service)	CIAL SECURITY NO. 17. IN	IFORMANT	Address	Sume
	- 2/2	-32-2975	Miss Paris	u Helmon	n adhen
		or (a), (b), and (c).]			ONSET AND DEATH
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	THEA	IA		
	581.0 DUE TO		ELLAN		
		1743 4	= EMMORUI	M KI ON	
	cause (a), stating the under-	PATIO 11	WFRX P	0 E P 1	DAKED BEAS
7	, (4	OTICE	1111	- 11) 0 - 1	AN LA LAD
CERTIFICATION	PART II. OTHER SIGNIFICANT CONDITIONS CON	TA A	NOT RELATED TO THE JERMINAL DI	SEASE CONDITION GIVEN II	PERFORMED?
PI Q	20- ACCIDENT WAS UNDERLYING TO 201 DESCRIB	E HOW INHIBY OCCUBRE	D. (Enter antice of injury in Part I o	r Port II of item 18 \	YES NO
ERTI	OR CONTRIBUTING CAUSE OF DEATH	E HOW INJURY OCCURE	D. (Enter nature at injury in rail to	r rair in at nem 10.)	
AL O		DY OCCUPRED 200 PL	ACE OF INITIAL Home form 206	(City or town)	(Caunty) (State)
MEDIC	Haur a. m. While	No while for		(cil) di alimi)	(Coomy) (Sidile)
X	p. m. of wark	a wark	-	1 -0	
	1	A .	and .		
	34	19 <u>6</u> /, and that a	death accurred at 250M, fr	am the causes and a	n the date stated above. 22b.DATE
	W A STA	NE	M.D. ATTENDING MEDICTOR	R PASS.	SIGNED
	22c. PHYSICIAN'S	Y	22d. ADDRESS		6-28-6
	NAME (Type) Mr D. STO	2240	Western 2	125/20	
230	BURIAL CREMATION, 23b, DATE THEREOF 2:	3c. NAME OF CEMETERY C	R CREMATORY 23d. L	OCATION (City, town, or co	unty) (State)
1	NMOVAL (Specify) 7/2-/6/	western	Ment Penil	to Pural	Instruste.
24.	FÜNERAL DIRECTOR'S SIGNATURE	ADDRESS -	25a. REC'D BY R	EGISTRAN 256, REGISTRA	K'S SIGNATURE The
	x-2- myloch- Mes	Thurston	MA " DATE 1111 3		of S. Kraus



MAKTLAND	SIAIL	PAKIMENI	OF REALIR
DIVISION OF STATISTICAL	RESEARCH AN	D RECORDS — B.	ALTIMORE 1, MARYLAND
		E OF DEAD	

66	24	CERTIFICA	TIE OF DEATH			06608
PLACE OF DEATH			2. USUAL RESIDENCE (W			ce before admission)
o. COUNTY Cam	coll	MARYLAND	o. STATE Maryland		COUNTY Monte	romerv
b. CITY OR TOWN	(If outside corporate limits, write	c. LENGTH OF STAY IN 16		outside corporate limi	ts, write RURAL and g	give nearest town)
RURAL ond give		25 days	Bethesda		154	>-7
d. NAME OF HOSP	PITAL (If not in hospital, give stre		d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?
Springfie	ld State Hospi	tal.	8018 Park	Lane		YES NO
NAME OF	First	Middle	Last	4. DATE	Month	Day Yeor
DECEASED (Type or print)	Griffin	Vann	Canada Sr.	OF DEATH	6	71, 19 67
SEX	6. COLOR OR RACE 7. MA	ARRIED NEVER MARRIED	8. DATE OF BIRTH	9. AGE	1 1	1 YEAR IF UNDER 24 HRS
Male		WED TO DIVORCED	11-17-1899	61	oirthdoy) Months	Doys Hours Min.
. USUAL OCCUPAT	ION (Give kind of work done 10	Db. KIND OF BUSINESS OR INDU		e or fareign country)	12. CITI	ZEN OF WHAT COUNTRY
	orking life, even if retired)	Flooring Contra	actor Virg	inia	71	SA
FATHER'S NAME	Olloractor	LTOOLTIS COLLEGE	14. MOTHER'S MAIDEN	The state of the s		Oh.
Taniffin D	makahami Camada		Sarah Elle	en Trainor		
	ratchard Canada		NFORMANT	ar ramor	Address	
es. no, or unknown)	(If yes, give war or dates of service)		No conital Doc			
nknown		unknown	Hospital Reco	oras		I to an annual parameters
	EATH [Enter only one couse per	r line for (o), (b), and (c).				ONSET AND DEATH
PARI I. DE	EATH WAS CAUSED BY: IMMEDIATE CAUSE (o)	longestive hear	t failure			Days
1073	DUE TO					
Conditions, if	ony, which ) (b) S	Syphilitic and a	arteriosclero	tic cardio	rascular	Years.
gove rise to couse (o), stotin	immediate (					
lying couse los	(c) (c)	lise ase.				
PART II. O	THER SIGNIFICANT CONDITION	IS CONTRIBUTING TO DEATH BU	T NOT RELATED TO THE TER	MINAL DISEASE COND	ITION GIVEN IN PAR	T 1(0) 19. WAS AUTOPSY
		associated wit	th Central Ne:	rvous Syste	em Syphili	S PERFORMED?
	vchotic reaction vas underlying   20b. D	ESCRIBE HOW INJURY OCCURR	ED. (Enter noture of injury in	n Port I or Port II of ite	em 1B.)	
OR CONTRIBUTIN	WAS UNDERLYING ☐ 20b. D NG ☐ CAUSE OF DEATH FY MEDICAL EXAMINER)					
PAM II. O Chronic with ps 20a. ACCIDENT V OR CONTRIBUTIN (IF EITHER, NOTIF  20c. TIME OF INJU Hour o. m p. m	URY Month, Doy, Year 20d	I. INJURY OCCURRED   20e. P	LACE OF INJURY (Home, for	rm, 20f. (City or town	1) ((	County) (State
Hour o.m	. Wh	ile Not while fo	octory, street, office bldg., e			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
p. m		work ot work				
21. I certify th	nat (1) (this haspital) atte	ended the deceased fram.	5-19 1	961, to 6-1	1, 19	61 that (I) (we) las
	ased alive an 6-14		death accurred at 8	A.M. fram the co	uses and an the	e date stated above
220. SIGNATURE	7,0	2 1				22b. DATE SIGNEI
le	worm de	Chmpo	M.D. PHYS.	MED. STAF	£ 6-1	11-61
22c PHYSICIAN		. //	22d. ADDRESS			
NAME (Type)	Agustin del	lCampo, M.D.	Spring	field State	Hospital	Sykesville,
a. BURIAL, CREMAT	ION, 23b, DATE THEREOF	23c. NAME OF CEMETERY			ity, town, or county)	(Stote)
Burial	6/16/61	Gate of He		Silver		Maryland
, FUNERAL DIRECTO		ADDRESS			25b. REGISTRAR'S SIG	
	A . Daminh mar-1	& Bethesda,	Manueland		arthur S.	
Chopant.	wordinguteh.	g. wetnesda,	Mar. ATAIL DALE			

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completely filled in by the funeral director, page 3 shauld be detached for use as the buriol-transit permit. Then please remove corbon papers. Pages 1 and 2 shauld be filed with the State Board of Health prior to burial, cremation, ar removal, and in any event within 72 hour after death. VR A1S (4) 1SM 9/S9

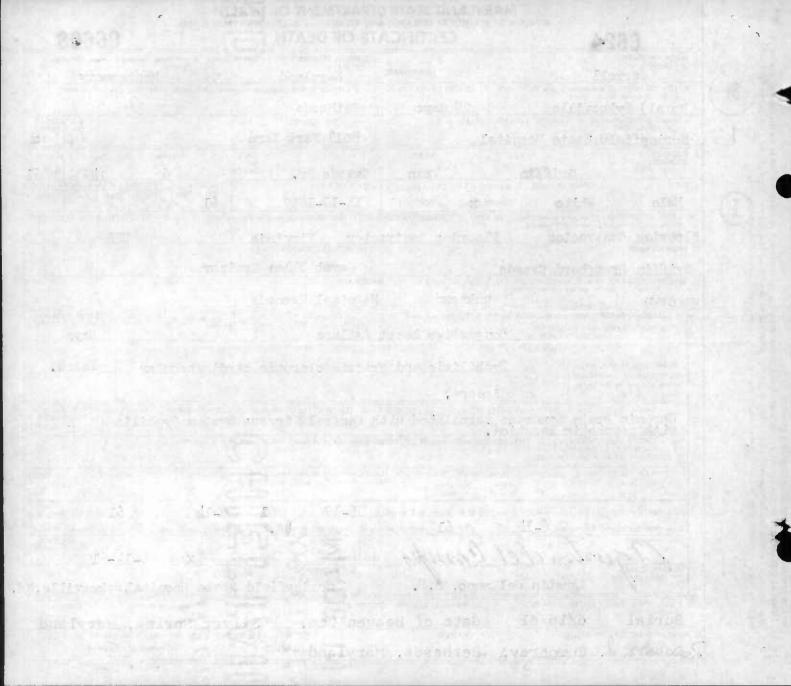
DING PHYSICIAN: The law requires that the death certificate be executed v

TO HOSPITAL OR

h. Page 4

24 hours after d

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1 MAI BALTIMORE 1, MARYLAND

SIICHE KESEMKOI	1 WIAM	VECOVD	J	
CERTIFIC	ATE	OF I	DEATH	1

25	CERTIFICATE	OI
4.0	T	

06600

662	5		CERTIFICA	IE OF DEATE	7		00003
PLACE OF DEATH a. COUNTY	arroll		MARYLAND	o. STATE Mary	rland	b. COUNTY	Residence befare admission) Frederick
b. CITY OR TOWN RURAL and give r Sykesv:			mos. Lidavs	c. CITY OR TOWN (III		limits, write RUR	(AL and give nearest tawn)
d. NAME OF HOSPI	TAL (If nat in haspital,			d. STREET ADDRESS	Church St		e. IS RESIDENC ON A FARM YES NO
NAME OF DECEASED (Type or print)		rst ert	Middle Josiah	Carty	4. DATE OF DEATH	Manth June	Day Year 15, 19 6
Male	6. COLOR OR RACE White	7. MARRIED [ WIDOWED	NEVER MARRIED DIVORCED	8. DATE OF BIRTH  March 7, ]	-		FUNDER 1 YEAR IF UNDER 24 I Manths Days Haurs M
Oa. USUAL OCCUPATI during mast af wa Lime kil	rking life, even if retired	dane 10b. KINI	O OF BUSINESS OR INDU	STRY 11. BIRTHPLACE (Sto		try)	12. CITIZEN OF WHAT COUNT
3. FATHER'S NAME  Jacob Ca	rty			Lou Ann I			
S. WAS DECEASED EV (Yes, no. or unknown)	ER IN U. S. ARMED FOI (If yes, give war or dotes of		IAL SECURITY NO. 17. II	Springfield	Hospital	Addres	
Canditians, if gave rise to cause (a), stoting lying cause last	immediate DUE To	c)	RIBUTING TO DEATH BUT Bruerioscier	NOT RELATED TO THE TER	minal disease c	ondition given	N IN PART 1(a) 19. WAS AUTO PERFORMED YES NO
OR CONTRIBUTIN (IF EITHER, NOTIF	AS UNDERLYING GAS CAUSE OF DEATH Y MEDICAL EXAMINER)  ORY Manth, Day, Yo	ear 20d. INJUR	RY OCCURRED 20e. PI	D. (Enter nature of injury  ACE OF INJURY (Hame, for	arm, 20f. (City or		(Caunty) (S
21. I certify the saw the deceder 220, SIGNATURE	at (I) (this haspita	while at wark  all) attended time 114,	the deceased fram.	Sept. 1,	1960 , toJun		
23a. BURIAL, CREMATI BREMOVAL (Specif 24. EUNERAL DIRECTO	0-18-1	OF 23	M.D.  IC. NAME OF CEMETERY C  Park Heig  ADDRESS	or Crematory	23d. LOCATIO	ON (City, town, or	caunty) (State)  RAR'S SIGNATURE

may be retained.

TO FUNERAL DIRECTON: After this certificate has been signed by the attending physicion and campletely filled in by the funeral director, page 3 shauld be detached for use as the burial-transit permit. Then please remove carban papers. Pages 1 and 2 shauld be filed with the State Board of Health prior to burial, cremotion, ar remaval, and in any event, within 72 haurs after death. 24 haurs after NDING PHYSICIAN: The law requires that the death certificate be executed

Page 4

TO HOSPITAL OR VR A15 (4) 1SM 9/S9

a mental C. anne THE REPORT OF THE PARTY OF THE alenger (iven a la recent traver principal de la recent de 

06610 **CERTIFICATE OF DEATH** 6626 Reg. Dist. No. 1 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 15 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give negrest town) d. NAME OF HOSPITAL (If not in hospital, give street address d. STREET ADDRESS e. IS RESIDENCE OR INSTITUTION ON A FARM? YES NO NAME OF Middle DATE Month Yeor DECEASED OF DEATH HUNE 6 (Type or print) 19 oges 9. AGE (In years lost birthdoy) IF UNDER 1 YEAR IF UNDER 24 HRS S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH Months Dovs Min Hours WIDOWED 47 DIVORCED cample 12. CITIZEN OF WHAT COUNTRY? USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (Stote or foreign country) during most of working life, even if retired) 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME remave IS. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. ANFORMANT Address [If yes, give war or dates of service] 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH d HROM SUSIS PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o) CORONA **DUE TO** ARTERIOSCUEROTIC CARDIOVASCULAR Conditions, if any, which gove rise to immediate DUE TO coese (o), stoting the underlying couse lost PART H. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO DO 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Port 11 of item 18.) 20c. TIME OF INJURY 20e. PLACE OF INJURY IHome, form, 20f. (City or town) Day. Year 20d. INJURY OCCURRED (County) (Stote) factory, street, office bldg., etc.) o. m. While Not while of work ot work JUNE 8 1961 that I last saw the deceased 21. I certify that I attended the deceased fram and that death occurred at 494 M, from the causes and an the date stated above. alive an ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE DIR pr. shauld PHYSICIAN'S WESTMINSTER NAME (Type) may be re 3 220. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (Stote) page REMOVAL (Specify 0 FUNERAL DIRECTOR'S SIGNATURE ADDRES 249 REC'D BY REGISTRAR 246. REGISTRAR'S SIGNATURE DATE 15M 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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TO HOSPITAL
death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. The law requires that the death certificate by

VR A15 (4) 15M 9/60 MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

- 01	041	GERTHIGAT	o or pertin			U6611
1. PLACE OF DEAT	н		2. USUAL RESIDEN	ICE (Whara dacaase	d lived, If Institution	nı Rasidanca bafore admission)
a. COUNTY	arroll	MARYLAND	•. STATE Ma	ryland	b. COUNTY M	iontgomery
b. CITY OR TOWN	(if outside corporate limits,	c. LENGTH OF STAY IN 16	c. CITY OR TOWN	(If outside corporate	limits, write RURAL	and give neerest town)
	11e	6yrs.10mos.2	Bdays Si	lver Spri	ng	1521-7
	ITAL OR INSTITUTION (if not in hos		d. STREET ADDRESS			a. IS RESIDENCE
	ield State Hospi	tal	16	Eastmoor	Drive	YES NO
3. NAME OF DECEASED (Typa or print)	Laura Lelea	h May Cas	teel	4. DATE OF DEATH	Month June	Pay Year 29, 1961
5. SEX	6. COLOR OR RACE 7. MARRIE	D NEVER MARRIED 1 8	. DATE OF BIRTH	9. AGI		R 1 YEAR   IF UNDER 24 HRS.
Female	White WIDOWE		December 2,1	875   last 81	birthday) Months	Days Hours Min.
10a. USUAL OCCUPAT	TION (Giva kind of work orking lifa, avan if retirad)	ND OF BUSINESS OR INDUSTR	TY 11. BIRTHPLACE (Cou			CITIZEN OF WHAT COUNTRY
	e	*	Mo.			U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN	NAME		
	rt H. May		Martha	Frances	Thompson	
15. WAS DECEASED EN	/ER IN U.S. ARMED FORCES? 16.	SOCIAL SECURITY NO. 17.	INFORMANT		Addrass	
No	If yas giva war or datas of servica)	-	Springfield	Hospital	Records	
18. CAUSE OF I	DEATH [Enter only one cause per li	ina for (a), (b), and (c).]				I INTERVAL BETWEEN
PART I. DEAT	H WAS CAUSED BY:	tening of the	hmein			ONSET AND DEATH
220	IMMEDIATE CAUSE (a)	centing of one	prain			Days
339	DUE TO					
Conditions, if any		clusion of cere	ebral artery			Days
gave rise to immad (a), stating tha u						
causa last.	) (c) Ger	eralized arter	riosclerosis			Years
Z PART II. OTHE	O CLOSHITLES AND CONTRIBUTIONS CON	TAIRLITING TO BELTIL OUT		NAL DISEASE COND	ITION GIVEN IN PA	
S ease wit	soc.with dist.of h psychotic reac	metab., growth	or nutrition	n with ser	nile brain	dis- PERFORMED?
20a. ACCIDENT W	AS UNDERLYING   20b. DES	CRIBE HOW INJURY OCCURED	. (Entar natura of injury in	Part I or Part II of ite	m 18.)	
	MEDICAL EXAMINER)					
ZOc. TIME OF INJU		1	CE OF INJURY (Home, fari		wn) (C	County) (Stata)
Hour a.m.	While 10 at work	1101 111110	ory, streat, office bidg., etc	• 1		
	that (I) (this hospital) attend		Assemble 6	10 El. to Team	20 1	1067 that (1) () In-
21. I Certify	Tayon 20	10 47	dgus.uug	12.20	18	SOFT that (i) (we) ias
	sed alive onJune29.		death occured at 1.	T: An the	causes and or	
22a. SIGNATURE	110: X-m	aresti-			AFF YS.	22b. DATE SIGNED
22c. PHYSICIAN'S	Tun -	)	22d. ADDRESS		2	June 30, 196
NAME (Type	Ellis Margoli	in, M.D.	Springfie	ld Hospita	al Sykesv	ille. Md.
23a. BURIAL, CREMAT REMOVAL (Spacify)	ION, 23b. DATE THEREOF	23c. NAME OF CEMETERY			(City, town or cou	
ransit-Buri		Princeton Ceme	terv	Mercer C	ounty, Mi	ssouri
24 FUNERAL DIRECTO	R'S SIGNATURE TOO OU	34 Georgia Ave		C'D BY REGISTRAR		
Roulmon 1	umphrey, Inc. 84	lver Spring M	In and DATE	IUL 5 '61	Cinchun	S. Kraus
1	51	Tyer Spring, K	aryland			

7.37 manter and the second I feedball velt foutster annual sustain femineren fin malastrat. - The class of the control of the co Then the winds we are the later to This dispersion I have been properly the second of the sec Tenest-Burtal T/3/61 Masser County, Mannour! Wagner S. Bagnirey, Inc. 5454 Capreils Avenue Silver Spring, Maryland

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as been signed by the attending physician and cample. Filled in by the fundral director,	ial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with	
d in by	ond 2	
filled	Pages 1	
cample	papers.	ath.
ion and	carbon	ofter de
3 physic	гетоме	2 hours
ottending	please	within 7
y the o	Then	event
igned b	permit	d in any
as been s	al-tronsit	aval, and in any event within 72 hours ofter death.

haspital or attending physicion. After this certificate has been sign my be retain the conficult of the conficulty by the registrar prior to buring the registrar prio

ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours often

TO HOSPITAL O

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RTIFICATE	OF DEATH	Rea. Dist. No	0

	66	528		CERTII	FICA	ATE OF DEAT	TH		Reg. Dist	. No.	66	12
1)	LACE OF DEATH b. COUNTY Carr	011		MARY	AND	2. USUAL RESIDENCE (		ed lived. If instituti b. COUNTY		e before	odmissi	on)
1		(If outside corporate lim	its, write	c. LENGTH OF STAY	N 16	c. CITY OR TOWN (		orote limits, write R			est fown	)
L	Union			Life		Union	town					
L	d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					d. ŠTREET ADDRESS				•		IDENCE FARM? NO
3.	NAME OF DECEASED	F	rst	Middle		Lost	4. DATE	Mon	th	Day	Y	Yeor
	(Type or print)	Anna	1041	Louella	3	Caylor	DEATH	June	15.		1	19 61
5.	SEX	6. COLOR OR RACE	7. MARR	IED NEVER MARRIE	D 🔲	8. DATE OF BIRTH		9. AGE (In years lost birthdoy)	IF UNDER 1		-	
	Female	White	WIDOWE	DIVORCED DIVORCED		October 12.	1875	85 yrs.	Months	Days	Hours	Min.
10c	. USUAL OCCUPAT	ION (Give kind of work	done 10b.	KIND OF BUSINESS OF	RINDUS	STRY 11. BIRTHPLACE (See	ote or foreign	country)	12. CITI	ZEN OF	WHAT	COUNTRY
	Housewi		1	Own home				Maryland	U	.S.	A	
13.	FATHER'S NAME					14. MOTHER'S MAIDEN	NAME					
	John 1	R. Wolf				Mary Ar	n Cort	in				
15.	WAS DECEASED E	VER IN U. S. ARMED FO	RCES? 16.	SOCIAL SECURITY NO.	17. N	NFORMANT		Add	ress			-
	no	(III yes, give wor or dates or	service)	none	Mr	s. Marshall	Myers.	Unionto	n. Ma	rv]s	and	
z	PART I. Di 422, Conditions, if gove rise to couse (o), stotin lying couse los	g the under-		teris Sile	rati	NOT RELATED TO THE TER		SE CONDITION GIV	/EN IN DART	The	TAND	
CERTIFICATION	20a. ACCIDENT V	VAS UNDERLYING  IG CAUSE OF DEATH FY MEDICAL EXAMINER)	20b. DESC			D. (Enter noture of injury			SIT III I ANI			RMED?
MEDICAL CI	(IF EITHER, NOTIF 20c. TIME OF INJU Hour o. m p. m	JRY Month, Day, Yo		Not while	20e. PL	ACE OF INJURY (Home, fo	orm, 20f. (Citetc.)	ty or town)	(Ce	ounty)		(Stote)
	21. I certify alive on ALL ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)	that I attended the	decease 196 M		4~ death	occurred at $\mathcal{G}$		m the causes of Street, city or town,			e state DA	
220	REMOVAL (Specif			22c. NAME OF CEME				ATION (City, town,		,	(Stote	)
23.	FUNERAL DIRECTO	Tune 19	1961	ADDRESS	Liem		C'D BY REGIS		rylani			
	6.8.Fus	S & Son	a)	Tancytown,	Mar		UN 19'6	4	lun S. t			

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#### MARYLAND STATE DEPARTMENT OF HEALTH

BALTIMORE 1, MARYLAND

	DIAISION OF	21 W113	HICAL RESEARCH AND R	CEC OKD3	_ DA
529		-1	CERTIFICATE	OF D	EAT

DEETS

662	9	74	CERTIF	200	OF DEATH	91,71			000		
1. PLACE OF DEATH o. COUNTY	arroll	J. OCIN	MARY	2.	o. STATE Mary		lived. If institution b. COUNTY		lto.		on)
RURAL and give r	(If outside corporate limited rest town)	ts, write	18yrs 9m		c. CITY OR TOWN (IF o	utside corporo	te limits, write R	URAL ond	give nea	rest town	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
d. NAME OF HOSPI OR INSTITUTION	TAL (If not in hospitol, garage and standard sta		oddress)		d. STREET ADDRESS	Frede:	rick Ave				IDENCE FARM? NO
3. NAME OF DECEASED (Type or print)	Mollie		Middle	(	Lost Chapman	4. DATE OF DEATH	June		26,		rear 19 61
Female	6. COLOR OR RACE White	7. MARR	DIVORCE		June 18, 18		. AGE (In years last burthday) yrs.	Months	Doys Doys	Haurs	R 24 HF
0a. USUAL OCCUPATI during most of wo	ON (Give kind of work rking life, even if retired	done 10b.	KIND OF BUSINESS O	R INDUSTRY	Washingto	_		12. CIT		.S.A.	
3. FATHER'S NAME Charles	Knoblock			1	4. MOTHER'S MAIDEN N		eeper				
IS. WAS DECEASED EV (Yes, no, or unknown)	ER IN U. S. ARMED FOR (If yes, give war or dates of		SOCIAL SECURITY NO		rmant ringfield Ho	spital	Records		13		
	the under DUE TO	A A	cute heart	fail	ure heart disea	ase			INTE	Hou Yea	rs rs
Schizoph	HER SIGNIFICANT CONTENTS OF THE TENTE TO THE	ion,	paranold t	ype.	Bronchopneu  Enter noture of injury in I	monia.		/EN IN PAI	RT 1(a) 1	9. WAS A PERFO	RMED?
OR CONTRIBUTION (IF EITHER, NOTIF)  20c. TIME OF INJU  Haur a. m. p. m.	G CAUSE OF DEATH Y MEDICAL EXAMINER)		NJURY OCCURRED Not while	20e. PLACE	OF INJURY (Home, farm y, street, office bldg., etc	, 20f. (City o			(Caunty)		(Sto
					th accurred a 0:0				e date	stated 221	abay
AZ2c. PHYS/LIAN'S NAME (Type)	Agustin d	lel Can	mpo, M.D.	M.C	ATTENDING MIDITAL MIDI	RECTOR D	staff Phys. 20	kesvi		6/26 Md.	/6T
23a. BURIAL, CREMATI REMOVAL (Specify		OF 61	23c. NAME OF CEM	ETERY OR C	REMATORY Parks	23d. LOCATI	ON (City, town,	or county)		(Stote	e)
	6-29	151	ADDRESS	0-10	Parks 250. REC'	Ball By REGISTR	tuno	or county)	IGNATUI		e)

TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physician and campletely filled in by the funeral directar, page 3 should be detached for use as the burial-transit permit. Then please remove carban papers. Pages 1 and 2 should be filed with the Stote Board of Health prior to burial, cremation, or removal, and in any event, within 72 pages ofter death.

UDING PHYSICIAN: The low requires that the death certificate be executed

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1. MARYLAND 6630 CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY b. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 16 RURAL and give nearest town) BRIDGE BRIDGE RAL d. NAME OF HOSPITAL (If not in haspital, give street oddress) IS RESIDENCE d STREET ADDRESS ON A FARM? OR INSTITUTION YES NO NAME OF 4. DATE Middle Year Month DECEASED JESSE (Type or print) 19 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS S. SEX 7. MARRIED NEVER MARRIED lost birthday) Manths Davs Haurs WIDOWED | DIVORCED [ 100, USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) LABORER 13. FATHER'S NAME ELIZABETH 17. INFORMANT 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 1B. CAUSE OF DEATH [Enter only one couse per line far (a), (b), and (c).] ONSET AND DEATH PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (6) Gears DUE TO Canditions, if any, which gove rise to immediate DUE TO couse (a), stoting the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO IX 20a. ACCIDENT WAS UNDERLYING CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 20c. TIME OF INJURY 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, 20f. (City or tawn) (Stote) Doy, Year (County) factory, street, office bldg., etc.) Hour o.m. While Not while at wark at wark 27/61, 19\_\_\_, that (I) (we) last 21. I certify that (I) (this haspital) attended the deceased fram. Le 1 , ta\_ saw the deceased alive and the date stated above. 22a. SIGNATUR 22b. DATE SIGNED ATTENDING PHYS. MED. 22c. PHYSICIAN 22d. ADDRESS NAME (Type 23a, BURIAL, CREMATION. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d, LOCATION (City, town, or county) (Stote) DRIAL (Specify) 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR'S SIGNATURE 25a. REC'D BY REGISTRAR DATE JUN 2 9 '61 arthur & Krous

MARYLAND STATE DEPARTMENT OF HEALTH

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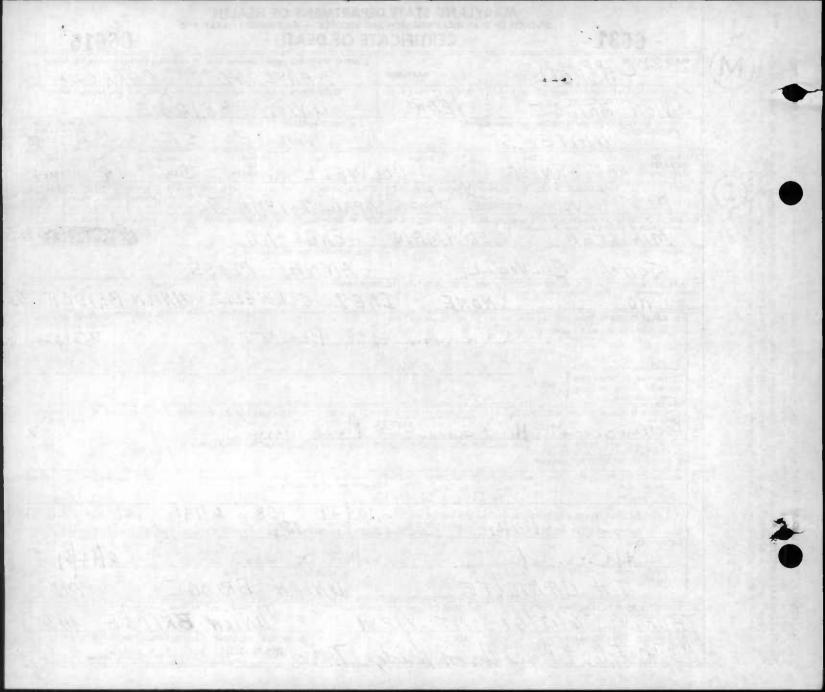
# MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

06615

1	1. PLACE OF DEATH	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
/	O. COUNTY CARROLL MARYLAND	O. STATE MARYLAND B. COUNTY CARROLL
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town)
	UNION BRIDGE YEARS	X UNION BRIDGE
П	d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS  e. IS RESIDENCE ON A FARM?
	WHITE ST	WHITE ST YES NO
	3. NAME OF DECEASED POPUL FIRST Middle	Last 4. DATE Month Day Year
	(Type or print) REV EKNEST COL	WELL DEATH June 14 1961
	S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED	B. DATE OF BIRTH  9. AGE (In years   IF UNDER 1 YEAR IF UNDER 24 HRS.   Months   Doys   Haurs   Min.
	/Y/ WIDOWED DIVORCED	APRIL 7-1871 90 yrs.
	10a. USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR INDU:	STRY 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT COUNTRY?
	MINISTER CLERGYMAN	ENGLAND
Н	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
h	JOHN COLWELL	ANNA MOSS
	1S. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. IN (Yes, no, or unknown) [ (If yes, give war or dates of service)	Address Address
	NO NONE 1	NEZ COLWELL UNION BRIDGE!
	18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), ond (c).]	INTERVAL BETWEEN ONSET AND DEATH
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)	the Prostate 25 us.
	177V DUE TO	
	Conditions, if ony, which ) (b)	
	gove rise to immediate couse (a), stating the under-	
	lying couse lost. (c)	
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT	NOT PELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED?
	3 arterio schroti Heart disease 3	reumania. YES NO D
)	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT  The state of the s	D. (Enter noture of injury in Part I or Port II of item 18.)
	= 11	ACE OF INJURY (Home, farm, 20f. (City or town) (Caunty) (Stote)
	Not while p. m. 19 While at work □	A
	21. I certify that (I) (this haspital) attended the deceased fram.	10 29 1958, to 6/14/ 196/, that (1) (we) last
	111110	death occurred a M, from the causes and on the date stated above.
	226. SIGNATURE	P2b. DATE
		M.D. PHYS. MED. STAFF PHYS.   4/14/6/SIGNED
	22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
	JH CARICOFE	UNION BRIDGE MD
	23g. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY O	R CREMATORY 23d. LOCATION (City, town, or county) (State)
	BURSPETT 6/17/61 MT VIE	W UNION BRIDGE MD
	24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
	NI Hastoker T Sono, Union Bride	DATE JUN 19'61 Cuthun S. Kraus

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remave carban pagers. Pages 1 and 2 shauld be filed with the State Boord of Health priar to burial, crematian, or remaval, and in any event, within 72 hours after death. 24 haurs after de DING PHYSICIAN: The low requires that the death certificate be executed

TO HOSPITAL O VR A1S (4) 1SM 9/59



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DING PHYSICIAN: The law requires that the death certificate be executed

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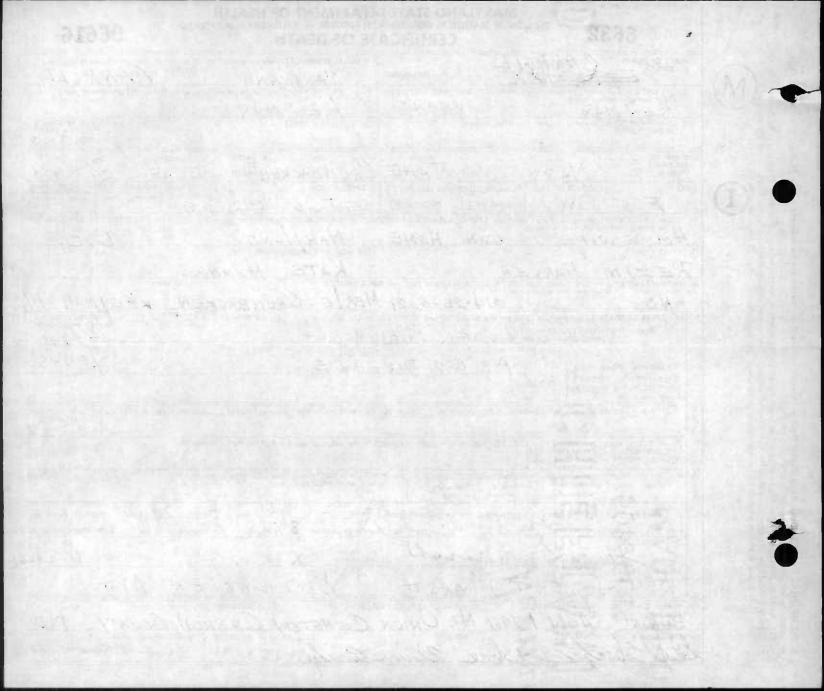
# MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

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	00	0.0		CERTIFIC	AIE OF D	EAIH		00	010
1. Pl.	ACE OF DEATH	CARR	04	MARYLAN	O STATE	DENCE (Where decease	d lived. If institution b. COUNTY	n: Residence befo	re odmission)
b.	RURAL and give no	1 5 9900	mits, write c. LE	NGTH OF STAY IN 1	CITY OR	OWN (If outside corpo	orate limits, write RU	RAL and give ned	arest town)
d.		AL (If not in hospito	, give street oddres	s)	d. STREET A	DORESS			e. IS RESIDENCE ON A FARM? YES NO
D	AME OF ECEASED ype or print)	MAR	First	Middle JANE	CRUME	4. DATE BACKER DEATH	Month	_	y Year 7 1961
s. SE	×	6. COLOR OR RAG	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	B. DATE OF BIRT	26 1892	9. AGE (In years lost birthdoy) 6 9 yrs.	Months Days	IF UNDER 24 H Hours Min
0a.	dyring most of work	ing life, even if retir	rk done 10b. KIND ed)	OF BUSINESS OR IN	DUSTRY 11. BIRTHPI	ACE (State or foreign of	ountry)	12. CITIZEN O	WHAT COUNTE
3. F.	ATHER'S NAME	FARI	IER		14. MOTHER'S	MAIDEN NAME	INES		
		R IN U. S. ARMED F (If yes, give war or dates		26 - 5329	MER LE	CRUMBA	Addre	KEY	MAR /
		TH [Enter only one TH WAS CAUSED B' IMMEDIATE CAUSE	1: 1	- 0 Di	u MONI.	4		ON	ERVAL BETWEEN SET AND DEATH
	422.		(b) A.S.	e. v. 7/3	SEASE			)	/EARS
	gove rise to i couse (o), stoting lying couse lost.		(c)						
CATION	PART II. OTH	IER SIGNIFICANT CO	ONDITIONS CONTR	IBUTING TO DEATH	BUT NOT RELATED TO	THE TERMINAL DISEAS	E CONDITION GIVE	N IN PART 1(a)	9. WAS AUTOP PERFORMED? YES NO
CER.	OR CONTRIBUTING	S UNDERLYING  CAUSE OF DEAT MEDICAL EXAMINE	'H]	HOW INJURY OCCU	RRED. (Enter noture o	f injury in Port I or Por	t II of item 18.)		
MEDICAL	Oc. TIME OF INJUR Hour o. m. p. m.	Y Month, Doy, 1	While t	OCCURRED 20e. Not while of work	PLACE OF INJURY ( foctory, street, office	Home, form, 20f. (City bldg., etc.)	y or town)	(County)	(Sto
	21. I certify that		4 41	ne deceased from	/	6 1961 , to	the causes one	/	ot (I) (we) to
	220. SIGNATURE	eures 3	. The	roh	M.D. ATTENDIN		STAFF PHYS.		6-29
	22c. PHYSICIAN'S NAME (Type)	JAMES	7.M	ARS H	22d. ADDR	ESTMIN.	STER	MD	
230.	BURIAL, CREMATIO REMOVAL (Specify)	N, 23b. DATE THE	EOF 23c.	NAME OF CEMETER	OR CREMATORY	23d. LOCA	TION (City, town, or	COUNTY	(Stote)
24.5	UNERAL DIRECTOR	SSIGNATURE	+ Sono	ADDRESS	x Bril	DATE JUL 3		TRAR'S SIGNATU	

may be retaine Aspertal or attending physician.

Defuneral pirector Africa this certificate has been signed by the attending physician and campletery fille page 3 shauld be detached for use as the burial-transit permit. Then please remave carban papers. Pages the State Board of Health prior to burial, cremation, or remaval, and in any event, within 72 hours offer death. TO FUNERAL DIRECTO TO HOSPITAL O VR A15 (4) 15M 9/59



# MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

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	0000	CERTIFICA	AIL OI DEAIII		
1. 1	PLACE OF DEATH o. COUNTY Darroll	MARYLAND	2. USUAL RESIDENCE (Where o. STATE	deceased lived. If institutions b. COUNTY	Residence before admission)
	b. CITY OR TOWN (If outside corporate limits, write RURAL oper give procest town)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If outsi	de corporate limits) write RUR	AL and give nearest town)
,	d. NAME OF HOSPITAL (If not in hospital, give street in hospital, give	Home	d. STREET ADDRESS	03 X ·	e. IS RESIDENCE ON A FARM? YES NO
	NAME OF DECEASED (Type or print) GEORGE	ENWAR	D DELA	DATE Month OF DEATH JUSCE	Day Year 6 1961
	Male White wido	ARRIED NEVER MARRIED DIVORCED DIVORCED	2-9-1873	S yrs.	FUNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
1	3. USUAL OCCUPATION (Give kind of work done 10 to the most of working life, even if ret red)	DE KIND OF BUSINESS OF IND		oreign country)	12. CITIZEN OF WHAT COUNTRY?
	Jesse E. D	ill	14. MOTHER'S MAIDEN NAM	ah Park	led
15. (Yes	WAS DECEASED EVER IN U. S. ARMED FORCES?  (If yes, give wor or dates of service)	16. SOCIAL SECURITY NO. 17.	INFORMANT WE Elbert R.	Robosson -	Randallstown, 7
	PART I. DEATH Enter anly one couse per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	rline for (a), (b), and (c).	, beart deser	u, Cerbril	INTERVAL BETWEEN ONSET AND DEATH
	Conditions, if ony, which (b)	ancular acce	deut Carlin	failure,	1957
	gave rise to immediate couse (a), stating the under- lying cause last.	brown lovin	Syndrme	U	6 June 61
CATION	PART II. OTHER SIGNIFICANT CONDITION	S CONTRIBUTING TO DEATH B	JT NOT RELATED TO THE TERMINA	L DISEASE CONDITION GIVEN	N IN PART 1(o) 19. WAS AUTOPSY PERFORMED? YES NO
CERTIFI	20a. ACCIDENT WAS UNDERLYING ACCIDENT WAS UNDERLYING (IF EITHER, NOTIFY MEDICAL EXAMINER)	PESCRIBE HOW INJURY OCCUR	RED. (Enter noture of injury in Part	I ar Port II of item 18.)	
MEDICAL	Haur o. m. Wh		PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
K	21. I certify that (I) (this haspital) atte	11	- A		an the date stated abave.
d	22a. SIGNATURE	Well 3	ATTENDING _ MED.	STAFF PHYS.	22b. DATE SIGNED
	22c. PHYSICIAN'S NAME (Type) HOWATO	E. HALL	22d. ADDRESS	herville	mi
230	BURIAL, CREMATION, 23b. DATE THEREOF BOMOVAL (Specify) 6-9-6/	23c. NAME OF CEMETERY	OR GRAMMORY 23	d. LOGATION (City, town, or	Bullo & Md.
24.	FUNERAL DIRECTOR'S SIGNATURE	Desceville	25a. REC'D B	104 13 11.	RAR'S SIGNATURE

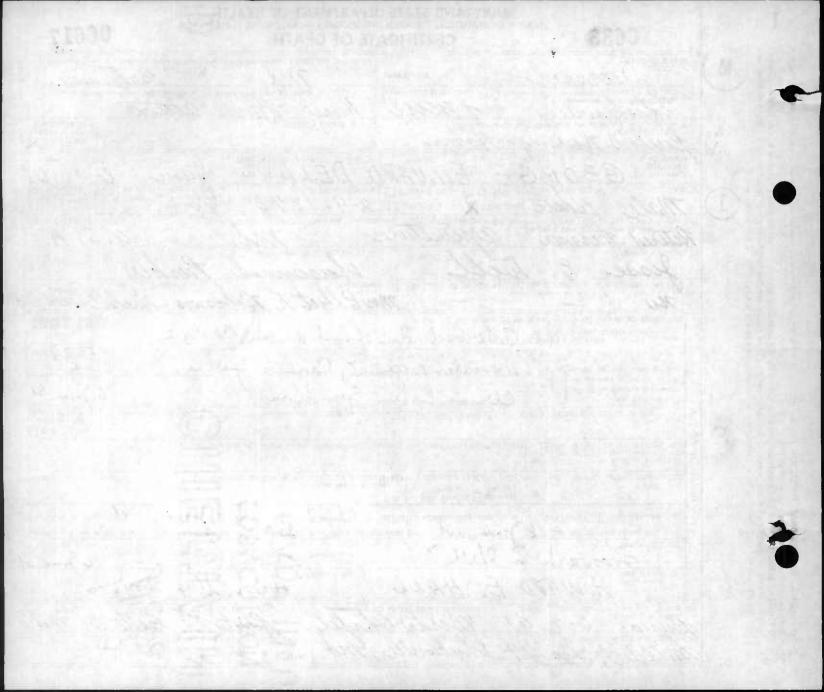
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**SEUNERAL DIRECTO**After this certificate has been signed by the attending physicion and completely filler page 3 should be detached for use as the buriol-transit permit. Then please remove corban pages. Pages the State Board of Health prior to buriol, cremation, or removal, and in any event, within 72 haurs after death. DING PHYSICIAN: The low requires that the death certificate be executed espitol or attending physicion.

TO FUNERAL DIRECTO TO HOSPITAL O

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ING PHYSICIAN: The law requires that the death certificate be executed my

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### MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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	0007								00013
1. PLACE OF DEATH o. COUNTY Carroll		MARYLAND		usual residence (Va. STATE Mar	Where deceas	ed lived. If institu b. COUNT	N.4	e before odmission)	
b. CITY OR TOWN (If autside carporate limits, write RURAL and give neprest town)  Sykesviile			c. LENGTH OF STAY IN 16		c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town)  Baltimore 18				
d. NAME OF HOSPITA OR INSTITUTION Spring:	AL (If not in hospital, gi	Hos	oddress) pital		d. STREET ADDRESS 605 W.	33rd	St.		e. IS RESIDENCE ON A FARM? YES NO
3. NAME OF DECEASED (Type ar print)	Minnie	Este	Middle Yagle		Ericson	4. DATE OF DEATI		onth ne	Day Year 13, 1961
5. SEX Female	6. COLOR OR RACE White	7. MARR	NEVER MARRIED DIVORCED		May 12, 18	88	9. AGE (In year last birthday 73	Manths	YEAR IF UNDER 24 HRS Days Haurs Min.
10a. USUAL OCCUPATIO during mast of work Stenogray	INDUSTRY	,,,				S.A.			
13. FATHER'S NAME  Jacob Ya	1	Johannah Weimeister							
1S. WAS DECEASED EVER (Yes, no. or unknown) (	R IN U. S. ARMED FORG If yes, give war or dates of se		SOCIAL SECURITY NO.	17. INFO	rmant ringfield	Hospit		ds	
	TH [Enter anly one con TH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO		ne for (a), (b), and (c).	bstru	ction				INTERVAL BETWEEN ONSET AND DEATH Days
Canditians, if ar gave rise to ir cause (a), stating lying cause last.  PART II. OTH	my, which (b) nmediate the under- (c)	I	olvulus of			RMINAL DISEA	SE CONDITION C	IVEN IN PART	Days  1(a) 19. WAS AUTOPS' PERFORMED?
0	onal psycho s underlying  CAUSE OF DEATH MEDICAL EXAMINER)		CRIBE HOW INJURY OC	CURRED. (I	Enter nature of injury i	in Part I ar Pa	art II af item 18.)		YES 🏝 NO 🗌
ZOc. TIME OF INJUR Hour a. m. p. m.		While	NJURY OCCURRED  Nat while k at wark	20e. PLACE factory	OF INJURY (Hame, for, street, affice bldg.,	arm, 20f. (Ci	ty ar tawn)	(C	aunty) (State
21. I certify tha		ie 13	19 61, and		ATTENDING PHYS.	MED. DIRECTOR D	staff Phys.	and an the	date stated above  22b. DATE 6/11/61  MODIUM MI
23a. BURIAL, CREMATIO BEMOVAL (Specify)	N, 23b. DATE THEREO	6/	23c. NAME OF CEME	TERY OR C	ONAL	Is	ATION (City, town	MD	(State)
24. FUNERAL DIRECTOR	S SIGNATURE F, DIR,	410	ADDRESS   EDMONA	25077	JUF DATE	JUN 1	STRAR 25b. RE	Cathur 2	



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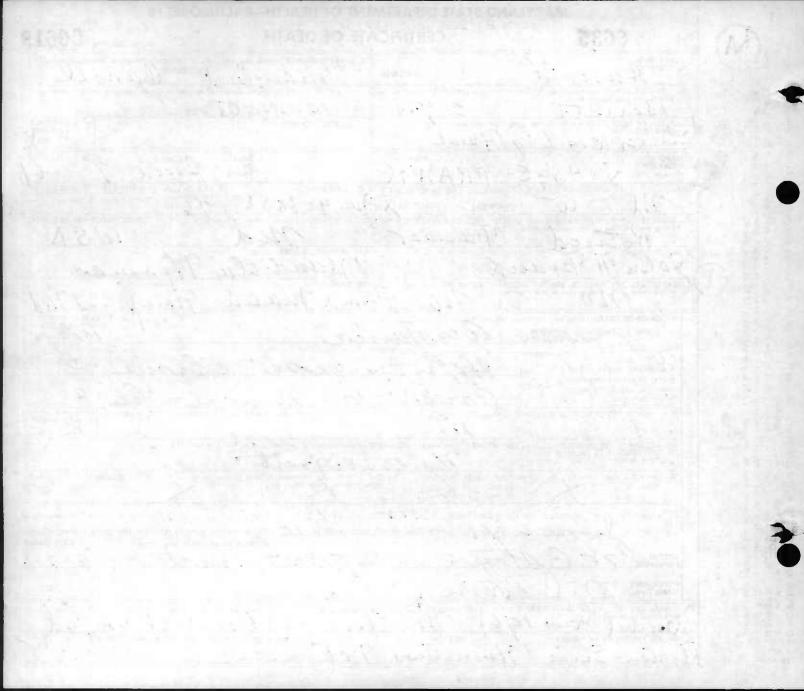
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## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

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PLACE OF DEATH O. COUNTY	Carroll	MARYLAND	D. STATE	/here deceased lived. If institution b. COUN	totion: Residence before admission) ITY Washington
	(If autside carporote limits, write nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (IF		e RURAL and give nearest tawn)
OR INSTITUTION		t address)	d. STREET ADDRESS		e. IS RESIDENC ON A FARM YES NO
	field State Hosp		IN OTTE		TES   NO
3. NAME OF DECEASED (Type or print)	Robert	Lee	Garver	4. DATE A OF DEATH	6 24 196
5. SEX Male	6. COLOR OR RACE 7. MAR WIDOW		8. DATE OF BIRTH June 18, 18	9. AGE (In year last birthday	rs. IF UNDER 1 YEAR 1F UNDER 24 Hours Mi
10a. USUAL OCCUPAT during most of wo Meat 1	ION (Give kind of wark done 10b grking life, even if retired) Cacking Co.	. KIND OF BUSINESS OR INDU	STRY 11. BIRTHPLACE (Stote		12. CITIZEN OF WHAT COUNT U.S.A.
13. FATHER'S NAME	Garver		Nannie -	NAME	
		. SOCIAL SECURITY NO. 17. II	Springfield	Hospital Rec	ords
Canditions, if gave rise ta couse (o), stotin lying couse los	ONY, which immediate g the under t. (c)	lateral pneumo	C.V. disease		yea rs
20g. ACCIDENT V	VAS UNDERLYING T 20b. DE	SCRIBE HOW INJURY OCCURRE			GIVEN IN PART 1(a)  PART 1(a)  PERFORMED  YES NO
(IF EITHER, NOTIF	. While	Nat while fa	ACE OF INJURY (Hame, for ctary, street, affice bldg., e	m, 20f. (City or town)	(Caunty) (Si
	nat (I) (this haspital) atten ased alive an 6/24			9 58 ta 6/24 304, Pram the causes	, 19 <u>61</u> , that (I) (we) and an the date stated abo
22a. SIGNATURE	estri del	Compo	M.D. ATTENDING PHYS. D	MED. STAFF PHYS.	22b. DAT 6/24/61
NAME (Type)	Agus offi de toan	mpo, M.D.		eld Hospital,S	Sykesville, Md.
23a. BURIAL, CREMAN REMOVAL (Specif			OR CREMATORY	23d. LOCATION (City, tow	IRB WASH, N
Scatt	T. Mennich	Sons Hager	stour DATE!	0.7101	EGISTRAR'S SIGNATURE Withur S. Kraus

TO HOSPITAL O VR A15 (4) 15M 9/59

Scott T. Mennigh Jone

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# moy be retained of the spital or attending physicion. TO FUNERAL DIRECTOL Parter this certificate has been signed by the ottending physicion and completely filled in by the funeral director, page 3 should be detached for use as the buriol-transit permit. Then please remove corbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to buriol, cremation, or removal, and in any event, within 72 hours offer death. G PHYSICIAN: The low requires that the death certificate be executed TO HOSPITAL O

VR A15 (4) 1SM 9/S9

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 6637

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1. PLACE OF DEATH o. COUNTY CARROLL			MARYL	AND	2. USUAL RESIDENCE (WO. STATE  MARYLAND	here deceased	d lived. If institution b. COUNTY	on: Resider	omer	re admiss	sion)
b. CITY OR TOWN	(If outside corporate limit	ts, write	c. LENGTH OF STAY IN	ч 1Ь	c. CITY OR TOWN (IF	outside corpo	rote limits, write R	URAL ond	give nea	rest town	n)
RURAL ond give	SYKESVILLE		Lymonths 9	da	ROCKVILLE	MARY	LAND	1	5	13	-1
d. NAME OF HOSE	PITAL (If not in hospital, gi	ive street	oddress)		d. STREET ADDRESS	-		-		e. IS RES	SIDENCE
OR INSTITUTION	D STATE HOS	отта 1			16510 Emory Lane						
				- 11				at .			
3. NAME OF DECEASED (Type or print)	Firs HELE		STARR TWISS	HAR	RISON	4. DATE OF DEATH	Mon 6	oth	2	16	19 61
5. SEX	6. COLOR OR RACE	7. MARI	RIED NEVER MARRIED	8	DATE OF BIRTH		9. AGE (In years lost birthdoy)				ER 24 HRS.
Female	White	WIDOW	ED DIVORCED	X	3/20/83		78 yrs.	Months	Days	Hours	Min.
100. USUAL OCCUPAT	TION (Give kind of work d	lone 10b.	KIND OF BUSINESS OR	INDUST	RY 11. BIRTHPLACE (Stote	e or foreign c	ountry)	12. CIT	IZEN OF	WHAT	COUNTRY?
	orking life, even if retired) acher, hsewf				Connect	dout		II	S.A	1	
13. FATHER'S NAME	TIPENT	9			14. MOTHER'S MAIDEN						
					Sarah						
	t Twiss Ver in u. s. armed for	CECO IV	SOCIAL SECURITY NO.	17 188	ORMANT	Starr	Add	raes			
(Yes, no, or unknown)	(If yes, give war or dates of se		SOCIAL SECURITY NO.	17. 1141		7-	Add	1633			
					Hospital re	cords				ERVAL BE	
Conditions, if gove rise to couse (o), stotin lying couse los	immediate by the under-	)		d ar	terioscleros					SET AND	
PART II. O Chronic  Chronic  20a. ACCIDENT V OR CONTRIBUTIN	Brain Syndr	ome	assoc. with	cer	ebral arteri	loscle	osis wit	h psy	chos	PERFC	RMED?
	WAS UNDERLYING A NG CAUSE OF DEATH FY MEDICAL EXAMINER)	20b. DES	CRIBE HOW INJURY OC	CURRED	(Enter noture of injury in	Port I or Por	t II of item 18.)				
20c. TIME OF INJ	1.	20d. I While of wor	Not while		CE OF INJURY (Home, far ory, street, office bldg., et		y or town)	(	County)		(Stote)
saw the dece	hat (I) (this haspital eased alive an6/	) attend 26/6			2/17/61 19 ath accurred at 5:	4 2 4	6/26/61 the causes ar			stated	
220. SIGNATURE	trude M	1.6	fron, le.	DN	.D. PHYS.	MED.	STAFF PHYS.		6/2	6/61	8b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type Gertrud		M.D.			Springf:	ield S	tate Hosp	ital			
230. BURIAL, CREMAT	(4) June 29,1	1961	23 MAME OF CEME	rsky or	GREMATORY CEMILERY	Mic	TIONSICITY, town,	Coun	41	(Sto	te)
24 FUNERAL DIRECTO	1. 4 /	541	ADDRESS TO	11/-	1100	C'D BY REGIS		STRAR'S	GNATU	RE	

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## DIVISION

MARYLAND STATE DEPARTMENT OF HEALTH
ON OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

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	1. PLACE OF DEATH a. COUNTY			K TEST TO SE		2. USUAL RESIDENCE	(Where decease	d lived. If instituti		e befare	admissi	ion) /
	Ca	arroll		MARYL	AND		yland	B. COUNT		egan	У	-
	b. CITY OR TOWN (If RURAL and give ned Sykesvi	prest town)	ls, write	6. LENGTH OF STAY IN Boyrs. 7 mos.		c. CITY OR TOWN	(If autside carpo berland	orate limits, write R	URAL and gi	ive near	st tawn	2
	d. NAME OF HOSPITA		ive street	-		d. STREET ADDRESS				e.	IS RESI	IDENCE FARM?
	Springf:	ield State	Hos	pital		126	Green	Street				NO 🔯
Ī	3. NAME OF DECEASED	Fir	st	Middle		Last	4. DATE OF	Mar	nth	Day	١	Year
	(Type or print)	Mary		$\mathrm{L}_{ullet}$		Hermann	DEATH	June		5,		19 61
	5. SEX	6. COLOR OR RACE	7. MAR	RIED NEVER MARRIED		DATE OF BIRTH		9. AGE (In years lost birthday)		Doys	Haurs	R 24 HRS. Min.
	Female	White	WIDOW	/ED DIVORCED		nknown		69 yrs.				
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  None  10b. KIND OF BUSINESS OR INDUSTRY  11. BIRTHPLACE (State or foreign country)  Maryland								12. CITIZEN OF WHAT COUNTRY?			
	13. FATHER'S NAME					14. MOTHER'S MAIDE	N NAME					
1	John L. He	ermann				Maggi	e McCul	ley				
1	15. WAS DECEASED EVER			SOCIAL SECURITY NO.	17. INF	DRMANT		Add	dress	4.41		
	(Yes, no or unknown)	f yes, give war or dates of s	er vice)	-	5	pringfield	Hospit	al Recor	ds.			
		TH [Enter only one co	-1111	ine for (o), (b), and (c).]						ONSE		TWEEN
1	A les 3	IMMEDIATE CAUSE (	) M	yocardial in	ifaro	tion				Da	lys_	
1	10	O - O DUE TO								37		
	Canditians, if on gave rise to im	mediate	,	rteriosclero	tic	heart dise	ase			TE	ars	•
	cause (a), stating t											
	Z PART II OTHI	FR SIGNIFICANT CON	DITIONS	CONTRIBUTING TO DEAT	TH RUT N	OT PELATED TO THE TE	PANINAI DISEAS	SE CONDITION GI	VEN IN PART	1(a) 19	WAS	AUTOPSY
	Mental :	Deficiency							YER HATTAKI		PERFO	RMED?
		S UNDERLYING [] [] CAUSE OF DEATH MEDICAL EXAMINER)	20b. DES	SCRIBE HOW INJURY OC	CURRED.	(Enter nature of injury	in Part I ar Pa	rt II af item 1B.)				
	20c. TIME OF INJURY Haur a. m. p. m.	Manth, Doy, Ye	While			E OF INJURY (Home, f rry, street, affice bldg.,		y or town)	(C	(aunty)		(Stote)
				ded the deceased f					, 19_6			
	22a. SIGNATURE	ed olive on_uu	116_2	1961 , and I	that de	ath occurred on s	* CDN, #FOM	the causes a	nd an the	dote		b. DATE
		tin de	16	hanha		D. PHYS.	MED. DIRECTOR	STAFF PHYS.			6/	SIGNED
	22c. PHYSICIAN'S			-	741	22d. ADDRESS	1 1 1 1 1 1			-	/	7/
	NAME (Type)	Agustin d	elCa	mpo, M.D.		Springf	ield Ho	spital,S	ykesvi	lle	Md.	
	23a. BURIAL, CREMATION PREMOVAL (Special)	6/8/6	OF /	Pose /	TERY OR	CREMATORY .	23d. LOCA	TION (City, Iown,	or caunty)	,	My (Stat	D.
	24. FUNERAL DIRECTOR'S	SIGNATURE	0	ADDRESS	10		REC'D BY REGIS		ISTRAR'S SIG	SNATURI		
1	Laurs	seein -	me	· lunt	111	DATE	JUN 8	'61 (	William &	the	LA	

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# MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

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LOR EV SING PHYSICIAN: The law requires that the death certificate be executed 124 haurs after dec. Page 4	ained their spital ar attending physician.	. DIRECTOR py for this certificate has been signed by the attending physician and campletely filled in by the funeral directar,	uld be detached far use as the burial-transit permit. Then please remave carban papers. Pages 1 and 2 should be filed with 🌡	aard of Health prior to burial, cremation, ar remaval, and in any event, within 72 haurs after death.
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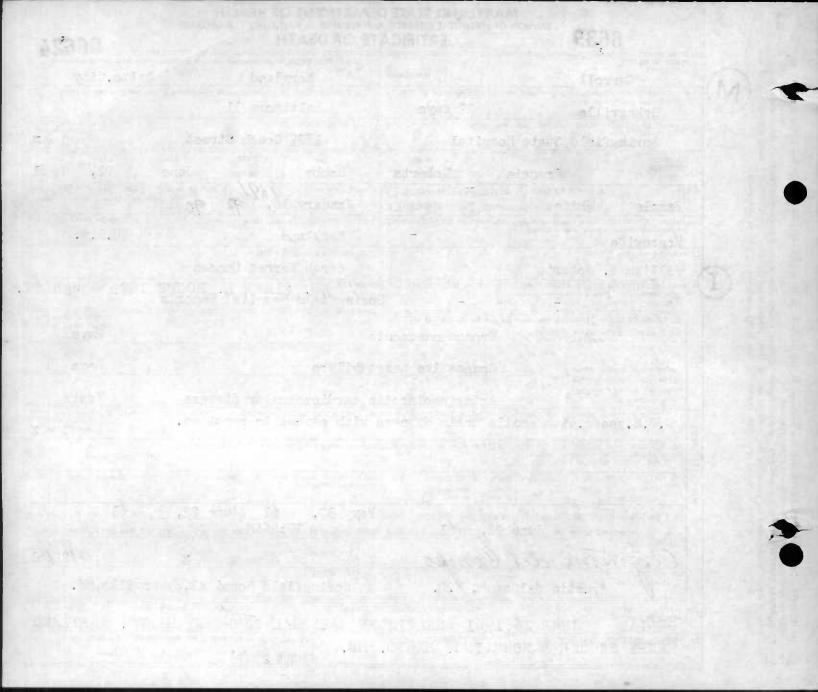
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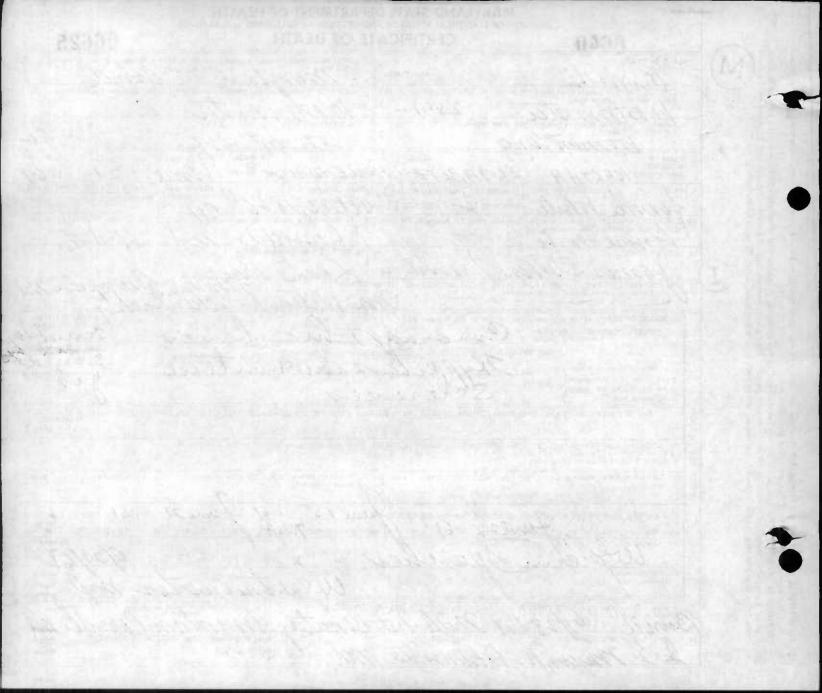
VR A1S (4) 1SM 9/59

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1. PLACE OF DEAT	Н				JSUAL RESIDENCE (WI	nere deceased live	h COLINITY -		
	arroll		MARYLAN	ID	Maryl	and	Ba	alto.	City
	N (If outside corporate lim ve nearest tawn)	its, write	c. LENGTH OF STAY IN 1	b	. CITY OR TOWN (If o		imits, write RURAL o	and give n	nearest town)
	sville		22 days:		Baltim	ore 31		320	1.4
d. NAME OF HO	SPITAL (If not in haspital,	give street	address)		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM?
Spri	ngfield Stat	e Hos	spital		1825 G	lough Str	eet		YES NO NO
3. NAME OF DECEASED (Type or print)	Fran	cis	Middle Roberts		Hobbs	4. DATE OF DEATH	June	2	Day Year 22, 19 61
S. SEX	6. COLOR OR RACE	7. MAR	RIED MEVER MARRIED	B. DA	TE OF BIRTH	189/ 9. A			AR IF UNDER 24 HRS
Female	White	WIDOW	/ED DIVORCED		January 16	, 1891	st birthdoy) Mont	ths Days	s Hours Min.
00. USUAL OCCUP	ATION (Give kind of work	done 10b.	. KIND OF BUSINESS OR IN	DUSTRY	11. BIRTHPLACE (Stote	or fareign country	1) 12	CITIZEN	OF WHAT COUNTRY
Housewi	working life, even if retired	1)	-		Maryland			U.	S.A.
3. FATHER'S NAME			ALC: 17 - 25 E. S.	14	MOTHER'S MAIDEN N	NAME			
William	E. Roberts				Sarah Mer	ret Dunc	an		
	EVER IN U. S. ARMED FOI	RCES? 16.	SOCIAL SECURITY NO.	7. INFOR	MANT MR. EL	MER L.	HOBBS" 1	.825	Gough S'
1B. CAUSE OF	DEATH   Enter only one of	ouse per li	ine for (o), (b), and (c).]	*					NTERVAL BETWEEN
The second second second	DEATH WAS CAUSED BY:	1	Bronchopneumo	mia					Days
110	IMMEDIATE CAUSE (		of offertopite unio	II.LO					24,5
720	2 DUE TO		Tannantira ha	ant s	há Tuma				Days
	o immediate i		Congestive he	arti	BILLUIE			-	Days
couse (o), stol	ting the under-			d. 1 .	3.	7 24			Vacue
lying couse I			Arteriosclero						Years
C.B.S.	assoc.with s	enil	contributing to death e brain disea	se w	ith psychot	react	ion.	PAKI I(0)	PERFORMED?
OR CONTRIBUT	WAS UNDERLYING [] TING [] CAUSE OF DEATH TIFY MEDICAL EXAMINER)	20b. DES	SCRIBE HOW INJURY OCCU	IRRED. (Er	iter nature of injury in	Port I or Part II o	item 18.)		
20c. TIME OF IN Hour o.				PLACE	OF INJURY (Home, farm street, office bldg., etc	n, 20f. (City or to	own)	(Count	ty) (Stote
Hour o.	m. m.	While		rociory,	street, office blog., etc	")			
		1) atten	ded the deceased fra	m Ma	v 30. 16	51 June	22.	0 61	that (I) (we) las
saw the dec	eased alive an II	me 2	2, 1961 , and the	at doct	accurred alo	KAMam the	causes and on		
22a. SIGNATUR		1 1	SELECTION OF THE PROPERTY OF T	ar dean	r decorred dagge	THE THE	caoses and on	THE GO	22b, DATE
an	notine de	101	andro	M.D.	ATTENDING MPHYS.	ED. ST	TAFF HYS. 🔼		6/22/61
22c. PHYSICIAN	ı'ş		Jan 1900		22d. ADDRESS	A STATE OF THE PARTY OF THE PAR			
NAME (Ty	Agustin de	elCam	po, M.D.		Springfiel	ld Hospi	tal, Sykes	ville	,Md.
23a. BURIAL, CREM.		OF	23c. NAME OF CEMETER	Y OR CR	EMATORY	23d. LOCATION	(City, town, or cour	nty)	(Stote)
REMOVAUSPE BURIA	L JUNE	26.1	961 BALTIN	MORE	NATIONAL	CEMETI	ERY BALT	'O. 1	MARYLAND
					2Sq. REC'	D BY REGISTRAR	25b. REGISTRAR		
24. FUNERAL DIRECT	SANDER &	SONS	INC. BALTO	). M	D. DATEIN	104	arthur 2		
					L DVIELLIN	2 11 W B			

DATEUN 2 6 '61



MARYLAND STATE DEPARTMENT OF HEALTH



## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

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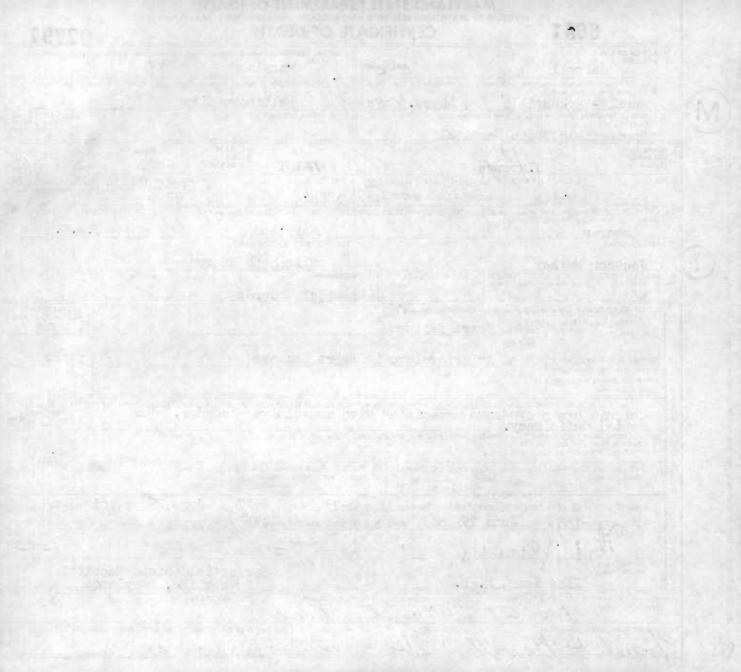
1.	o. COUNTY	rroll		MARYL		USUAL RESIDENCE	(Where deceased yland	d lived. If instituti b. COUNTY		e befar	e admiss	ion)
	b. CITY OR TOWN (I	If autside corporate limit	ts, write	c. LENGTH OF STAY I	N 1b	c. CITY OR TOWN	(If outside corpo	rote limits, write F	URAL ond g	ive nea	rest town	1)
		Sykesville		Lilyrs.6da	ys	Bal	timore C	ity	3	V	0	-6
/		TAL (If not in hospital, g		address)		d. STREET ADDRES	SS			-	e. IS RES	FARM?
		ield State	Hosp	ital		part to val						] NO [3
3.	NAME OF DECEASED	Fire	st	Middle		Last	4. DATE	Mor		Day	,	Yeor
	(Type or print)	Clare				HURLEY	DEATH	JUNE		29	)	1961
S.	. SEX	6. COLOR OR RACE	7. MAR	RIED NEVER MARRIE	D 💢 B.	DATE OF BIRTH		9. AGE (In years lost birthday)	IF UNDER			_
	Male	White	WIDOW	ZED DIVORCED		1884?		77 yrs.		Days	Hours	Min.
10	a. USUAL OCCUPATIO	ON (Give kind of work of king life, even if retired)	done 10b	. KIND OF BUSINESS OF	RINDUSTR	Y 11. BIRTHPLACE (S	State or foreign o	ountry)	12. CITI	ZEN OF	WHAT	COUNTRY
	Labore					Marvla	nd			U.S.	.A.	
13	B. FATHER'S NAME	1 1 1 1 1 1 1 1 1				14. MOTHER'S MAID						
1	Jackson	Hum? ove				Elizah	eth Henr	·V				
	. WAS DECEASED EVE	R IN U. S. ARMED FOR		SOCIAL SECURITY NO.	17. INFO			M	fress			
t,	Yes, no, or unknown)	(If yes, give war or dates of so	ervice)		Hos	spital Rec	orde					
-	+	ATH   Enter only one co	use per l	line for (a), (b), and (c).]		proar nec	01 40			INTE	RVAL BE	TWEEN
		TH WAS CAUSED BY:	TT								Weel weel	
	420	IMMEDIATE CAUSE (o	,	art failure						-	14001	156
		6 DUE TO		+ + +	- U	ant Digon				470	ears	
	Canditions, if o	mmediate		teriosclerot	TC U	sart Disea	136			, y	our 9	
	cause (o), stoting	the under-										
12	lying couse lost.	) (c	DITIONS	CONTRIBUTING TO DEA	THE DUST NO	OT RELATED TO THE	FRANKIAS DIEFAE	S CONDITION OF	VENI INI DADI	1/-> 1/->	O VA/AC	ALITOPSY
CATION	Chronic	brain synd	rome	contributing to DEA	with	convulsi	ve disor	der, plu	1S	1(0)	PERFC YES	JKMEUY
CEPTIEI	20a. ACCIDENT WAR	AS UNDERLYING CONTROL CAUSE OF DEATH MEDICAL EXAMINER)	20b. DE	SCRIBE HOW INJURY OF	CCURRED.	Enter nature of injur	y in Port I or Por	t II of item 18.)				
1	20c. TIME OF INJUR	RY Month, Day, Yes	or 20d.	INJURY OCCURRED	20e. PLAC	OF INJURY (Home,	form, 20f. (City	or town)	10	County)		(Stote
MEDICAL	Haur a.m.	19	While		factor	y, street, office bldg.	., etc.)					
3		· · · · · · · · · · · · · · · · · · ·	_	ork at work	/	00	7.77	T 00		3		
				ded the deceased			Δ	June 29				(we) las
		sed alive an	me_2	29_1961 and	that dec	th accurred at	UM, fram	the causes a	nd an the	date		
	220. SIGNATURE	# Ad A.				ATTENDING	MED	STAFF			22	29-6
	3 7	1 Jun	1/1	4	M.I	D. PHYS.	DIRECTOR [	STAFF PHYS.			0-	29-0.
	22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS		Leld Stat			al	
		Ilse Kamm	. M.	D.			Sykes	ville, M	arylan	d		
2:	3a. BURIAL, CREMATIC REMOVAL (Specify)		F /	The ana	TERY OR	Board	23d. LOCA	TION (City, town,	or county)		(Stot	te)
2	4. FUNERAL DIRECTOR	'S SIGNATURE		ADDRESS	-	25a.	REC'D BY REGIS	TRAR 2Sb. REG	ISTRAR'S SIC	SNATUR	RE	
1	Tucare K	H Hear	all	Pelan	8	my DATI	E 1111 1 0 '	61		4		4.19
	7	7 1 1000		7					Many -	7000	A.M.	

Page 4

24 haurs after dec

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 2 shauld be filed with page 3 should be detached for use as the burial-tronsit permit. Then please remave carbon papers. Pages the State Board of Health priar to burial, cremation, or remaval, ond in any event, within 72 hours after death ING PHYSICIAN: The law requires that the deoth certificate be executed spital ar attending physician. T T

may be retained TO HOSPITAL O VR A1S (4) 1SM 9/S9





Poge 4 director,

VR A1S (4) 1SM 9/S9

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06626

66	42		CERTIFICA	TE OF DEAT	H		U	6621	6
1. PLACE OF DEATH a. COUNTY Carroll			MARYLAND	2. USUAL RESIDENCE o. STATE Marylan		b. COUNTY	n: Residence bei	are odmissio	on)
b. CITY OR TOWN (IF RURAL ond give nec Henryton	irest town)	4	c. LENGTH OF STAY IN 16	c. CITY OR TOWN	own			100	3-
d. NAME OF HOSPITA OR INSTITUTION Henryton	State Ho			d. STREET ADDRESS	liams Av	enue		e. IS RESIL ON A I YES	FARM?
3. NAME OF DECEASED (Type or print)		rst nna	Middle Catherine	Johnson Lost	4. DATE OF DEATH	June		-/	ear 9 <b>61</b>
Female	6. COLOR OR RACE Negro	7. MARRIE	DIVORCED DIVORCED	8. DATE OF BIRTH 1-8-20	9	AGE (In years lost birthdoy) 41 yrs.	Manths Days	T	R 24 HRS Min.
Oa. USUAŁ OCCUPATIO during most of warki Housewif	ng life, even if retired	done 10b. K	IND OF BUSINESS OR INDU		ote ar foreign cou		12. CITIZEN	S. A.	OUNTRY
3. FATHER'S NAME  Roy Edway	rd			14. MOTHER'S MAIDE Unknown	N NAME				
5. WAS DECEASED EVER				NFORMANT Anna C. Joh	nson - I	Addr. Patient	ess		
Conditions, if on gave rise to im cause (a), stating to lying cause last.  Part II. OTH	ne diote he <u>under-</u>	c)	Atus Convuls		ERMINAL DISEASE	CONDITION GIV	EN IN PART 1(a)	19. WAS A	UTOPSY
PART II. OTH  20g. ACCIDENT WAS OR CONTRIBUTING (IF EITHER, NOTIFY)	CAUSE OF DEATH	20b. DESC	RIBE HOW INJURY OCCURR	ED. (Enter nature af injury	in Part I or Part I	II of item 1B.)		YES	
20c. TIME OF INJURY Haur a. m. p. m.	Manth, Doy, Yo	While		LACE OF INJURY (Hame, octary, street, affice bldg.,		ar tawn)	(Caunt	(4	(Stote
saw the decease	alive an Ju	ne 7,	ed the deceased fram. 19_61, and that	death accurred at?	19 <b>61</b> , ta 2:45, pom	June 7		te stated	abave .DATE
22c. PHYSICIAN'S	edgars M. Edgars M.		nlary	M.D. ATTENDING DATE PHYS. DATE PHYS.	MED. DIRECTOR   n State	Hospita	al, Hen	6-7-6 ryton	
23a. BURIAL, CREMATION REMOVAL (Specify)	23b. DATE THERE		23c. NAME OF CEMETERY O			ON (City, town, c	et, md.	(Stote	:)
24. FUNERAL DIRECTOR'S	SIGNATURE	k H	ADDRESS		JUN 13 '6		STRAR'S SIGNAT		

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6-2-61				
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## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

06627

CERTIFICATE	OF	DEAT
CERTIFICATE	OF	DEAT

1. PLACE OF DEATH o. COUNTY Carroll	MARYLAND	2. USUAL RESIDENCE (Where deceded on STATE Maryland	ased lived. If institution b. COUNTY	: Residence before admission)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest Jown)  YKESVILLE	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside co	rporote limits, write RUI	RAL and give nearest town)
d. NAME OF HOSPITAL (If not in hospitol, give street of or institution Pullen Hursing Home	ddress)	d. STREET ADDRESS 4314 Colborne R	d	e. IS RESIDENCE ON A FARM?/ YES NO (
3. NAME OF DECEASED (Type or print) CLARA First	F JOH	NSON 4. DAT	ปาาทอ	13 Doy (eor 61
5. SEX Female 6. COLOR OR RACE 7. MARRI White WIDOWEI	71	B. DATE OF BIRTH 9/13/180		FUNDER 1 YEAR IF UNDER 24 HRS Months Doys Hours Min.
10a. USUAL OCCUPATION (Give kind of work done 10b. K during most of working life, even if retired) NOUSEWIIE	at home	STRY 11. BIRTHPLACE (State or foreig	n country)	12. CITIZEN OF WHAT COUNTRY
13. FATHER'S NAME Augustus Friede		14. MOTHER'S MAIDEN NAME Lousia Neur	hr	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes. no. or unknown) (If yes, give wor or dates of service)		man graphing an	Douglas Marriottsvi	,
18. CAUSE OF DEATH [Enter only one couse per line PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (o), stating the under- lying couse lost.  PART II. OTHER SIGNIFICANT CONDITIONS CO	terroslutes al mululery.			ONSET AND DEATH  1459  12 Jone 6  N IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO 17
OR CONTRIBUTING CAUSE OF DEATH U (IF EITHER, NOTIFY MEDICAL EXAMINER)		D. (Enter noture of injury in Port I or		
Hour o. m. While	Not while of work	ACE OF INJURY (Home, farm, 20f. (ctory, street, office bldg., etc.)	City or town)	(County) (State)
21. I certify that (I) (this haspital) extends saw the deceased alive an 12.	21-00 es	ATTENDING 4 MED.	m the causes and	an the date stated above
22c. PHYSICIAN'S NAME (Type)	HOU	M.D. PHYS. DIRECTOR  22d. ADDRESS  A LACOR  M.D. PHYS. DIRECTOR	ille m	13 June 6
236. BURIAL, CREMATION, 236. DATE THEREOF 6/15/61	23c. NAME OF CEMETERY O	B	cation (City, town, or altimore, 11d	l. (
24 FUNEPAL DIRECTOR'S SIGNATURE	ADDRESS	250 DECED BY DEC	ICTRAR OCL PECIST	DAD'C CICNIATURE

JUN 1 6 '61

Outling & King

DATE

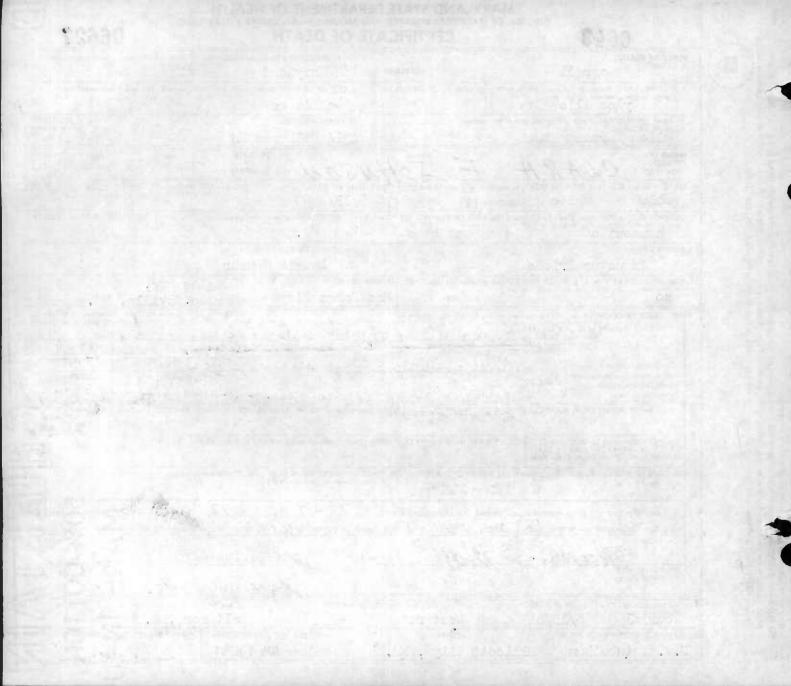
may be retained of the aspital ar attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remove carban papers. Pages 1 and 2 should be filed with the State Board of Health priar to burial, premation, or removal, and in any event within 72 haurs after death. G PHYSICIAN: The law requires that the death certificate be executed

TO HOSPITAL O VR A15 (4) 15M 9/59

F.C. Higinbothom

Ellicott City



Page 4

6644

NG PHYSICIAN: The law requires that the death certificate be executed

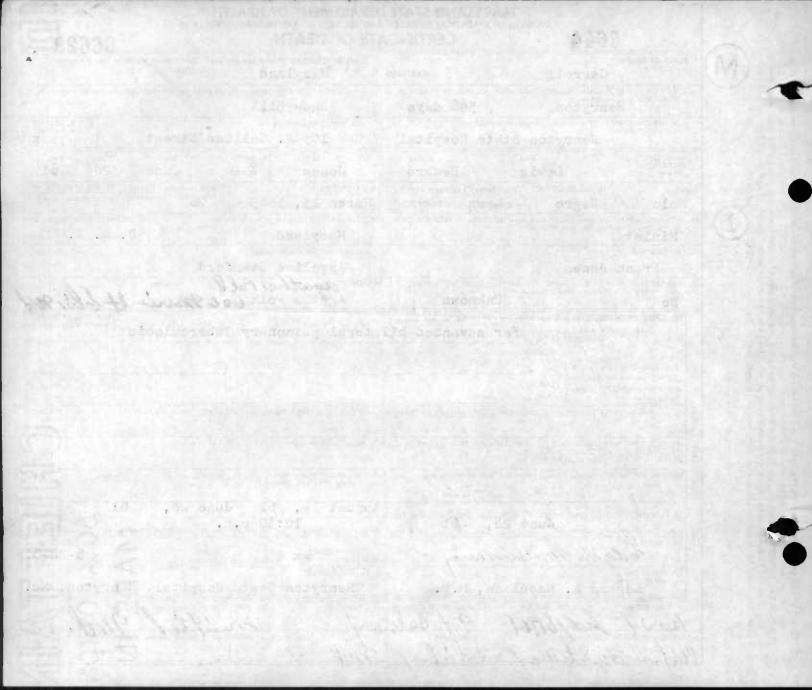
VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Carroll	MARYLAND	2. USUAL RESIDENCE (WE a. STATEMarylar	nere deceased lived. nd b	If institution: Reside	Vove
b. CITY OR TOWN (If autside carporate limits, we RURAL and give nearest town)  Henryton	546 days	c. CITY OR TOWN (IF a		its, write RURAL and	give nearest tawn)
d. NAME OF HOSPITAL (If not in hospital, give store in National Henryton Store	tate Hospital	d. STREET ADDRESS 105 S.	Collins	Street	e. IS RESIDENCE ON A FARM? YES NO
3. NAME OF First DECEASED (Type or print) Lewis	Middle Howard	Jones	4. DATE OF DEATH	June June	28 161
37 3	MARRIED NEVER MARRIED DOWERS DIVORCED	B. DATE OF BIRTH March 15, 18		(In years bythday) Months  yrs.	R 1 YEAR IF UNDER 24 HRS. Days Haurs Min.
10a. USUAL OCCUPATION (Give kind af wark dane during most af warking life, even if retired)  Minister	10b. KIND OF BUSINESS OR INDU	STRY 11. BIRTHPLACE (State Maryland	ar fareign cauntry)		. S. A.
13. FATHER'S NAME  Frank Jones		14. MOTHER'S MAIDEN N			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give wor or dates of service)	16. SOCIAL SECURITY NO. 17. III	Agatha Po	olk 606	Address	1+ bl: 34
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  Part II. OTHER SIGNIFICANT CONDITIONS  COLUMN 10	ONS <u>CONTRIBUTING TO DEATH B</u> UT	NOT RELATED TO THE TERM	inal disease cond	DITION GIVEN IN PA	ART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO
OR CONTRIBUTING CAUSE OF DEATH	DESCRIBE HOW INJURY OCCURRE	D. (Enter nature of injury in	Part I ar Part II af it	em 18.)	
Haur a.m.	/hile Nat while fa t wark at wark	ACE OF INJURY (Hame, farm ctary, street, affice bldg., etc		n)	(Caunty) (State)
22a. SIGNATURE	28, 191, and that o	death accurred at	M, from the co	auses and an th	61, that (I) (we) last the date stated above. 22b. DATE 6-28 GB1
22c. PHYSICIAN: NAME (Type) Edgars M. Macul		22d. ADDRESS			enryton, Md.
23a. BURIAL, CREMATION, 23b. DATE THEREOF BEMOVAL (Specify)	23c. NAME OF CEMETERY C	OR CREMATORY	23d. LOCATION (C	tity, tawn, ar county)	mid.
24. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	Med DATE UL	D BY REGISTRAR	25b. REGISTRAR'S S Cuthun S.	



### MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6645

### CERTIFICATE OF DEATH

Reg. Dist. No. 06628

				Keg. Dist. No.
1. PLACE OF DEATH °. COUNTCAPPOLI	MARYLAND	2. USUAL RESIDENCE (Who o. STATE Md.	ere deceased lived. If institut b. COUNTY	tion: Residence before admission)  Y  Carroll
b. CITY OR TOWN (If outside corporate RURAL and give nearest town) Finksburg	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If o	outside corporote limits, write	RURAL and give nearest town)
d. NAME OF HOSPITAL (If not in hospitor INSTITUTION Rt. 1 Box 13		d. STREET ADDRESS Rt. 1 Box	137	e. IS RESIDENCE ON A FARM? YES AN NO
3. NAME OF DECEASED (Type or print)	First Middle Melvin T. Kaufn	nan lost	4. DATE Mo OF DEATH J	une 28 1961
5. SEX male 6. COLOR OR RA	ACE 7. MARRIED NEVER MARRIED WIDOWED DIVORCED	8. DATE OF BIRTH 9/8/15	9. AGE (In years lest birthdoy) 45 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of w during most of working life, even if re INSPECTOR	rork done 10b. KIND OF BUSINESS OR IND fired) Balto. City Wa		or foreign country)	12. CITIZEN OF WHAT COUNTRY USA
13. FATHER'S NAME Elmer Kaufma	n	14. MOTHER'S MAIDEN N		
15. WAS DECEASED EVER IN U. S. ARMED (Yes, no, or unknown) (If yes, give wor or date	et of service) long Connect Cl. O	informant Corinne T. K		ksburg, Md.
Conditions, if ony, which	BY:	y Thronto lucia	zi	INTERVAL 8ETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT OF CONTRIBUTING CAUSE OF DE CHIEFE, NOTIFY MEDICAL EXAMIN	CONDITIONS CONTRIBUTING TO DEATH BU			VEN IN PART 1(o) 19. WAS AUTOPS' PERFORMED? YES NO
7	Year 20d, INJURY OCCURRED 20e. F	PLACE OF INJURY (Home, form octory, street, office bldg., etc.	, 20f. (City or town)	(County) (Stot
ACTUAL SIGNATURE	the deceased from hov.  1961, and that deat  Mae anglesi  C. McLaughlin	th accurred at 11,10	AMfram the causes at ADDRESS (Street, city or town	that I last saw the decease and an the date stated above, stole)  Output  Compared to the date stated above, stole)  Output  Compared to the decease of the date stated above, stole)
220. BURIAL, CREMATION, 22b. DATE TH REMOVAL (Specify) 6/30	/61 Loudon Pa		22d. LOCATION (City. lown, Balto, M	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbar	d 4107 Wilkens Av			SISTRAR'S SIGNATURE

Page 4 may be retained by the spital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 shauld be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shauld be filed with the registrar priar to burial, crematian, ar remayal, and in any event within 72 haurs after death. 24 haurs after dec VG PHYSICIAN: The law requires that the death certificate be executed TO HOSPITAL OR VS A15 (4) 15M 9/58

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		Louden Park.	YOU bending	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

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PLACE OF DEATH a. COUNTY Carroll				LAND	o. STATE Mary	rland	b. COUNTY			/
RURAL and give nea	rest tawn)						rate limits, write R	URAL and giv	e nearest tow	m)
d. NAME OF HOSPITA	(If nat in haspital, gi	ve street oddre			d. STREET ADDRESS			. "	ON	SIDENCE A FARM?
Springfield	State Hos	pital			800 E.	Balti	more Str	eet #2	YES [	] NO 🔼
NAME OF DECEASED (Type or print)			Middle		Kitt	4. DATE OF DEATH	Man	th	11	191
male male	6. COLOR OR RACE white	7. MARRIED WIDOWED			5-30-05		9. AGE (In years birthday) yrs.			1
during most of working salesman	(Give kind af wark d ig life, even if retired)	ane 10b. KIND	OF BUSINESS C	R INDUSTR			ountry)			COUNTRY
FATHER'S NAME Abraham	Kitt									
es, no, ar unknown) (If	yes, give war or dates of se	rvice)		. 17. INFO		cords	Add	ress		
T				]					INTERVAL B	ETWEEN
PART I. DEATI	WAS CAUSED BY:	Corona	ary Occl	usion					5 min	
gave rise to im	mediate (	Arter	rioscler	osis					5 year	'S
lying cause last.  PART II. OTHE	(c)					INAL DISEAS	E CONDITION GIV	'EN IN PART	PERF	ORMED?
20a. ACCIDENT WAS OR CONTRIBUTING [	UNDERLYING					Part I ar Par	t II of item 1B.)		YES [	NO 🖺
		While	Nat while	20e. PLAC facta	E OF INJURY (Hame, farrry, street, affice bldg., et	m, 20f. (City	ar tawn)	(Ca	unty)	(State
21. I certify that (I) (this haspital) attended the deceased from March 25, 19 60 to June 11, 1961, that (I) (we) last										
220 SIVATURE 22b. DATE										
22c. PHYSICIAN'S NAME (Type)	Myron Ni	nkowsł	cy, M.D		Springfie	eld Sta	ate Hospi	tal		
REMOVAL (Specify)	6-14-6	F 23c	her a	ha	CREMATORY	23d. LOCA	Dalte	ar caunty)	The	e
FUNERAL DIRECTOR'S	SIGNATULE	100	DDRESS	× 00	2Sa. REC	D BY REGIST	RAR 25b, REGI	STRAR'S SIGN	NATURE	
	PLACE OF DEATH  C. COUNTY  Carroll  b. CITY OR TOWN (If a RURAL and give need of the control of	Carroll b. CITY OR TOWN (If autside carporate limit RURAL and give nearest town)  (Rural) Sylcestille d. NAME OF HOSPITAL (If not in hospital, gior in National Sylcestille) d. NAME OF HOSPITAL (If not in hospital, gior in National Sylcestille) SEX 6. COLOR OR RACE White d. USUAL OCCUPATION (Give kind of wark of during most of warking life, even if retired) SEX 6. COLOR OR RACE White D. USUAL OCCUPATION (Give kind of wark of during most of warking life, even if retired) SEX 6. COLOR OR RACE White D. USUAL OCCUPATION (Give kind of wark of during most of warking life, even if retired) SEX 6. COLOR OR RACE White D. SEX 6. COLOR OR R	PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town) Rural) Sylvesville d. NAME OF HOSPITAL (If not in haspital, give street oddre OR INSTITUTION Springfield State Hospital  NAME OF DECEASED (Type or print)  SEX 6. COLOR OR RACE White Widowed Marking life, even if retired)  S. USUAL OCCUPATION (Give kind af work done during most of working life, even if retired)  S. USUAL OCCUPATION (Give kind af work done during most of working life, even if retired)  S. ALESMAN  FATHER'S NAME Abraham Kitt  WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCI.  WAS DECEASED EVER IN U. S. ARMED FORCES? 11. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the under lying cause last.  PART II. OTHER SIGNIFICANT CONDITIONS CONT  Manic depressive reaction OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  20c. TIME OF INJURY Manth, Day, Year 20d. INJURY Hour a.m. p. m. 19 at work  21. I certify that (I) (this haspital) attended to saw the deceased alive on June 11  22a/ SIGNATURE  22c. PHYSICIAN'S NAME (Type)  MYTON NIEMNOWS!	PLACE OF DEATH  a. COUNTY  Carrol  b. CITY OR TOWN (if autside carporate limits, write RURAL and give nearest town)  (Rural) Sylesville  d. NAME OF HOSPITAL (if not in hospital, give street address)  OR INSTITUTION  Springfield State Hospital  NAME OF DECEASED (Type or print)  SEX  Male  Abraham Kitt  WAS DECEASED EVER IN U. S. ARMED FORCES? In no, or unknown)  IB. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).  PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a)  DUE TO  Canditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DE  Manic depressive reaction, mani  20a. ACCIDENT WAS UNDERLYING   OR CONTRIBUTING TO DE  Manic depressive reaction, mani  20a. ACCIDENT WAS UNDERLYING   OR CONTRIBUTING TO DE  Hour a. m.  p. m.  19  21. I certify that (I) (this hospital) attended the deceased saw the deceased dive on June 11 19 61, and  22a SUNALURE  WYON WAS DECEASED EVER  While of INJURY COURRED  While of Work   of Work   OR Work    While of Work   OR Work    Arterioscler  While of Work   OR Work    While of Work   OR Work    22a SUNALURE  WYON NIEWNOWSKY, M.D.  ACURIAL CREMATION, 23b. DATE THEREOF  LENGTH OF ENDLY   OR CENTRE OF	PLACE OF DEATH  C. COUNTY  Carroll  Cirroll  Cir	PLACE OF DEATH  0. COUNTY Carroll  b. CITY OR TOWN (If outside corporate limits, write RURAL and give necess town)  c. CITY OR TOWN (If outside corporate limits, write RURAL and give necess town)  b. CITY OR TOWN (If outside corporate limits, write RURAL and give necess town)  c. CITY OR TOWN (IF MATT)  d. STREET ADDRESS  G. COLOR OR RACE First Middle  CITY OR TOWN (IF MATT)  FIRST MAME OF HOSPITAL (If not in hospital, give street oddress)  OF INSTITUTION  SEX  G. COLOR OR RACE 7. MARRIED   NEVER MARRIED   8. DATE OF BIRTH  5-30-05  SUSUAL OCCUPATION (Give kind of work done lob. KIND OF BUSINESS OR INDUSTRY IN. BIRTHPLACE (Stote Matter)  SALE STREET ADDRESS  OF DECEASED  WIDOWED DIVORCED   8. DATE OF BIRTH  5-30-05  SUSUAL OCCUPATION (Give kind of work done lob. KIND OF BUSINESS OR INDUSTRY IN. BIRTHPLACE (Stote Matter)  SALE STREET ADDRESS  AND ADDRESS  MATT  14. MOTHER'S MADDEN  SALE STREET ADDRESS  MATT  15-30-05  MATT  KILL  MATT  16. COLOR OR RACE 7. MARRIED   NEVER MARRIED   8. DATE OF BIRTH  5-30-05  II. BIRTHPLACE (Stote Matter)  SALE STREET ADDRESS  MATT  16. SOCIAL SECURITY NO. II. BIRTHPLACE (Stote Matter)  SALE STREET ADDRESS  SALE STREET ADDRESS  MATT  16. STREET ADDRESS  MATT  MIDDING   No. STREET ADDRESS  MATT  MIDDING   No. STREET ADDRESS  MATT  A. DATE OF BIRTH  5-30-05  II. BIRTHPLACE (Stote Matter)  17. INFORMANT  HOSPITAL RESIDENCE (Stote Matter)  18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY.  MARCE OF DEATH (Enter only one couse per line for (a), (b), and (c).]  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM  MAN COURT OF THE MATTER OF THE	PLACE OF DEATH C. COUNTY CARTOLI  b. CITY OR TOWN (If cubids corporate limits, write RURAL and give necrest town)  RURAL and R	PLACE OF DEATH  0. COUNTY CATTOIL  1. CITY OR TOWN (If outside corporate limit, write RURAL and give necrest town)  RIVERIA and give necrest town)  RIVERIA and give necrest town  RIVERIA AND CLURATION (Give lind of work done los stricts)  RIVERIA AND CLURATION (Give lind of work done los stricts)  RIVERIA AND CLURATION (Give lind of work done los stricts)  RIVERIA AND CLURATION (Give lind of work done los stricts)  RIVERIA AND CLURATION (Give lind of work done los stricts)  RIVERIA AND CLURATION (Give lind of work done los stricts)  RIVERIA AND CLURATION (Give lind of work done los stricts)  RIVERIA AND CLURATION (Give lind of work done los stricts)  RIVERIA AND CLURATION (Give lind of work done los stricts)  RIVERIA AND CLURATION (Give lind of work done los stricts)  RIVERIA AND CLURATION (Give lind of work done los stricts)  RIVERIA AND CLURATION (Give l	PLACE OF DEATH  0. COUNTY Carroll  1. CITY OR TOWN (if outside corporate limits, write   C. LENGTH OF STAY IN 16   L. CITY OR TOWN (if outside corporate limits, write   RURAL and giv   Rural   L. CITY OR TOWN (if outside corporate limits, write   RURAL and giv   Rural   L. CITY OR TOWN (if outside corporate limits, write   RURAL and giv   Rural   L. CITY OR TOWN (if outside corporate limits, write   RURAL and giv   Rural   L. CITY OR TOWN (if outside corporate limits, write   RURAL and giv   Rural   L. CITY OR TOWN (if outside corporate limits, write   RURAL and giv   Rural   L. CITY OR TOWN (if outside corporate limits, write   RURAL and giv   Rural   L. CITY OR TOWN (if outside corporate limits, write   RURAL and giv   Rural   L. CITY OR TOWN (if outside corporate limits, write   RURAL and giv   Rural   Rural   L. CITY OR TOWN (if outside corporate limits, write   RURAL and giv   Rural   Rural   L. CITY OR TOWN (if outside corporate limits, write   RURAL and giv   Rural   Rural   L. CITY OR TOWN (if outside corporate limits, write   RURAL and giv   Rural   Rural   L. CITY OR TOWN (if outside corporate limits, write   RURAL and giv   Rural   Rural	PLACE OF DEATH  C. COUNTY  CATTOLI CATTOLI CATTOLI D. CITY OR TOWN (If outside corporate limits, write a cutton of the county) CATTOLI D. CITY OR TOWN (If outside corporate limits, write a cutton of the county) CATTOLI CATTOLI D. CITY OR TOWN (If outside corporate limits, write a cutton of the c

Page 4

may be retained by the pspital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physician and campletely filled in by the funeral directar, page 3 should be detached for use as the burial-transit permit. Then please remave carban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, crematian, ar removal, and in any event, within 72 hours after death. G PHYSICIAN: The law requires that the death certificate be executed TO HOSPITAL O

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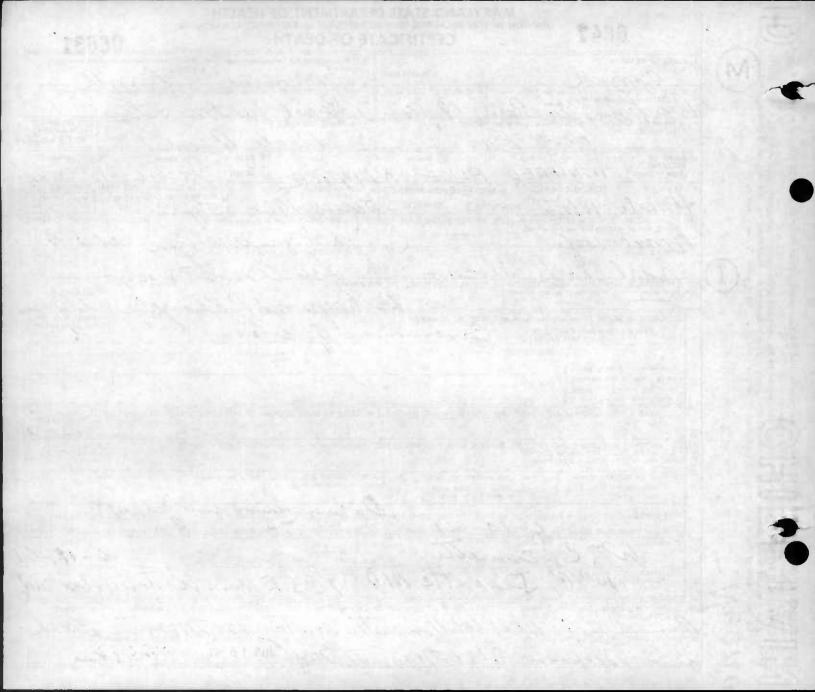
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# MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMODE 1 MARE

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o. COUNTY	. 10	MARYLAND	a. STATE	b. COUNTY	ence before damission)
b. CITY OR TOWN (If RURAL and give nea		LENGTH OF STAY IN 16	c. CITY OR TOWN If outside c	orporote limits, write RURAL on	d give nearest tawn)
d. NAME OF HOSPITA OR INSTITUTION	I (If not in hospital), give street addr	ess) glass	d. STREET ADDRESS	Day d	e. IS RESIDENCE ON A FARM? YES NO
3. NAME OF DECEASED (Type or print)	WINIFRED A	Middle	Lost 4. DA OF DE	ATH Month	Day Year // 19 6/
5. SEX	6. COLOR OR RACE 7. MARRIED WIDOWED	- INC. CO. CO.	DATE OF BIRTH 1906	9 AGE (In years leading to the state of the	ER 1 YEAR IF UNDER 24 HRS. s Days Hours Min.
Manager -	(Give kind of work done 10b. KINI ng life, even if retired)	OF BUSINESS OR INDUSTR	Jackson 7	gn country) 12.0	CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME	Clark Slo	cum 1	MOTHER'S MAIDEN NAME	metron	4
(Yes, no, or unknown) (II	f yes, give war or dates of service)	Dr.	Raymund 1	P. Klangle S	aldress
PART I. DEAT	H [Enter only one cause per line for H WAS CAUSED BY: IMMEDIATE CAUSE (o)	(0), (b), and (c).]	of color	1-	ONSET AND DEATH
Canditions, if on gove rise to im couse (o), stoting the	mediote (		0		
Iying couse last.   PART II. OTHE	r significant conditions <u>con</u>	FRIBUTING TO DEATH BUT N	OT RELATED TO THE TERMINAL DIS	SEASE CONDITION GIVEN IN P.	ART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO
	CAUSE OF DEATH	HOW INJURY OCCURRED.	(Enter nature of injury in Part I or	Port II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Manth, Doy, Year 20d. INJUF 19 While at work	Nat while focta	E OF INJURY (Home, farm, 20f. ry, street, affice bldg., etc.)	(City or town)	(Caunty) (Stote)
saw the decease	(1) (this hospital) attended ed alive on 6-10-	11	th occurred of ZAM, fr	- //	the dote stoted above.
22c. PHYSICIAN'S	"Come	the M.	ATTENDING MED. PHYS. DIRECTOR 22d. ADDRESS	STAFF PHYS.	6 - IRSIGNED
NAME (Type)	SMC, SENN	etle My	103 510	lain Wedn	instar ud
23a. BURIAL, CREMATION REMOVAL (Specify)	6/14/6/1	ADDRESS	CAMERIA 23d. LO	OCATION (City, town, or county  Company of County	to med.
X-2-7	mers he	Vestrans	JUN 1	E 101	1 S. Kraus

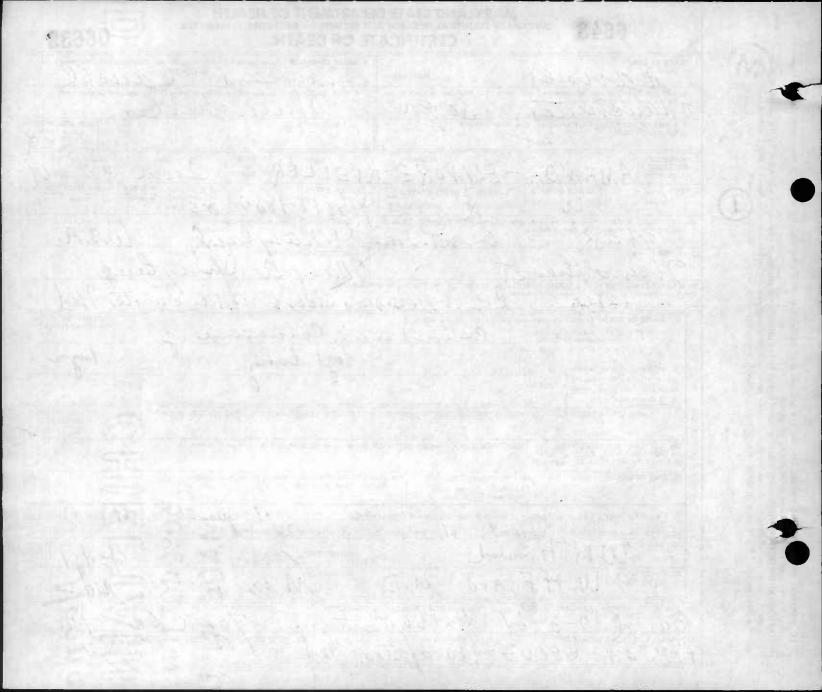


VR A1S (4) 1SM 9/S9 6648

# MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

06632

	PLACE OF DEATH O. COUNTY MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY
	b. City OR TOWN (If autside corporate limits, write RURAL and give nearest town)	c. CITY OR JOWN (If autside corporate limits, write RURAL and give nearest town)
	d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES \( \sum \) NO \( \sum \)
	NAME OF DECEASED (Type or print) AMANDA - ELINORE -	KNELLER 4. DATE OF Month June 30 1961
5. 5	6. COLOR OR RACE 7. MARRIED NEVER MARRIED WIDOWED DIVORCED	B. DATE OF BIRTH  9. AGE (In years less birthday)  9. AGE (In years less birthday)  Wanths Days Hours Min.
	USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	e Manfland WS.A.
	Heury Theiset	Mary a Griegling
	WAS DECEASED EYED IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17.  In no, or unknown)  12-16-94620	has short manchester und
	18. CAUSE OF DEATH [Enter anly one couse per line far (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  BY  O  O  O  O  O  O  O  O  O  O  O  O  O	genic Carcing of INTERVAL BETWEEN ONSET AND DEATH
	Conditions, if any, which gave rise to immediate (b)	legt lung. 1 yr.
z	couse (o), stoting the under   DUE TO   lying couse last. (c)	UT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY
CERTIFICATION		PERFORMED? YES NO PERFORMED? YES NO PERFORMED?
	OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
MEDICAL	20c. TIME OF INJURY         Manth, Day, Year         20d. INJURY OCCURRED         20e.           Hour o. m.         p. m.         19         While at work at work at work at work at work.         20e.	PLACE OF INJURY (Home, form, factory, street, affice bldg., etc.) (City or town) (County) (Stote)
		n. Dec
	220. SIGNATURE IN Fround	M.D. ATTENDING MED. STAFF DIRECTOR PHYS.   4346/SIGNED
	22c. PHYSICIAN'S NAME (Type) W. H. FOARD. M.D.	). 22d. ADDRESS MANchester, Md.
Ý	Burnal 1-3-61 Dubbs	Cetherare 1000 (City, town, or county) (State)
7	FUNERAL DIRECTOR'S SIGNATURE IPTON-KLINE-Paseful	Lad The Jul 5 161 25b. REGISTRAR'S SIGNATURE



in 24 haurs after de

ING PHYSICIAN: The law requires that the death certificate be executed

TO HOSPITAL Q

VR A1S (4) 1SM 9/59

## 6649

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

0	0	0	2	-
0	0	0	3	3

	1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY  Maryland  Carroll							
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
	Kevmar			Life		Ke	vmar					
	d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES \( \sum \) NO \( \sum \)						
	NAME OF DECEASED	Fi	rst	Middle		Last		DATE OF	Man	th	Day	Year
	Type or print)	F.		Estella		Koons		DEATH		June	10.	19 67
S. :	EX	6. COLOR OR RACE	7. MARR	IED NEVER MARRIED	B. 1	DATE OF BIRTH		9. A	GE (In years	IF UNDER Months		JNDER 24 HRS.
	Temale	White	WIDOWE	DIVORCED		Septembe	r 22.	1870	90 yrs.	Montes	Doys H	ours min.
	. USUAL OCCUPATIO		done 10b.	KIND OF BUSINESS OR						12.CITI	ZEN OF WH	AT COUNTRY?
1	None	ing me, even il terrec	"			Marv	land	156.6		Ţ	I.S.A.	
13.	FATHER'S NAME	V. Felley-				14. MOTHER'S M	AIDEN NAME					
	George	W. Koons				Sono	h Bos	tion				
15.	WAS DECEASED EVER	R IN U. S. ARMED FOR	RCES? 16.	SOCIAL SECURITY NO.	17, INFO		ui bos	ULAII	Adda	ess	4100	
(Ye		If yes, give war or dates of t	service)		1	07 7 77		2 / viir =	1/41 04	173	A 4 -	1- 36.5
-	no			none	IMT.	Clyde K	oons,	10 W.	LATA ST	Fre		AL BETWEEN
			ouse per lir	ne for (a), (b), and (c).]	5		1					AND DEATH
	PART I. DEATH WAS CAUSED BY: Acute myocardetes											
	431	DUE TO	)		/							
	Canditions, if only, which )											
	gove rise to immediate OUE TO											
	couse (a), starting the under-											
TION		J (c		CONTRIBUTING TO DEA	TH BUT NO	OT RELATED TO T	HE TERMINAL	DISEASE CO	NDITION GIV	'EN IN PAR	P	ERFORMED?
5											YE	S NO
L CERTIFICATION	20a. ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY	S UNDERLYING []  CAUSE OF DEATH  MEDICAL EXAMINER)	20b. DESC	CRIBE HOW INJURY OC	CURRED.	Enter noture of i	njury in Port	l or Port II o	f item 18.)			
MEDICAL	20c. TIME OF INJUR Hour o, m, p. m.	Y Month, Doy, Ye	While of worl	Not while		OF INJURY (Ho y, street, office b		Of. (City or t	own)	((	County)	(Stote)
	21. I certify tha	t (I) (this haspita	1) attend	led the deceased f	ram	6-10	196/	, ta _ 6	-10-	196	1. that	(I) (we) last
		ed alive an		- 196), and		th accurred			causes an	d an the	date sto	ated abave.
	22o. SIGNATURE	20.00	h			0.00011.00				- 411 1110	30.0	22b. DATE
		0	1,1	V. Lea	2 9 M.		MED.	OR D	TAFF HYS.	351		SIGNED
	22c. PHYSICIAN'S NAME (Type)	7,	14,	LEGIS	m	22d. ADDRESS	wie	ne v	Bri	da		me
230	BURIAL, CREMATIO	N, 23b. DATE THERE	OF	23c. NAME OF CEME	TERY OR C	REMATORY	23d	. LOCATION	(City, town,	or county		(State)
230	BURIAL, CREMATIO REMOVAL (Specify) Burial	June 13.	1000						(City, town, oburg, N		and	(State)
	REMOVAL (Specify)	June 13,	1000			ery 2		adies REGISTRAR	burg, N		GNATURE	(State)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH 6650Reg. Dist. No director, iled with PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) filed o. COUNTY a. STATI b. COUNTY MARYLAND the funeral shauld be fi b. CITY OR TOWN (If outside corporate limits, write c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 RURAL and give nearest town) latmenales ESTMINSTER d. NAME OF HOSPITAL (If not in hospital, give street address) e. IS RESIDENCE da STREET ADDRESS OR INSTITUTION ON A FARM? 294 by E MAIN YES NO DE TEADOW VIEW NURSING and 2. NAME OF 4. DATE Middle Month Year filled DECEASED KOONS DEATH Pages (Type or print) 196 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 5. SEX 6. COLOR OR RACE B. DATE OF BIRTH 7. MARRIED NEVER MARRIED campletely lost birthday) Months WIDOWED | DIVORCED | papers. 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT COUNTRY? death. during mast of working life, even if retired) HOME ond HOUSEKEEPER OWN rban ofter 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 5 HANN physici 550UR remave Address 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO INFORMANT OONS attending NO YERSIDE AVE, JACKSONVILLE 18. CAUSE OF DEATH [Enter only one couse per line\_far\_fa), (b), one NTERVAL BETWEEN NSET AND DEATH a PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Then the DUE TO p Conditions, if ony which permit gned gave rise to immediate DUE TO cause (o), stating the underlying couse lost. burial-transit physician been PART 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? has YES NO attending 20a. ACCIDENT WAS UNDERLYING [ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Port II of item 18.) certificate OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20 OS 20c. TIME OF INJURY Day, 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f, (City or town) Year (Stote) (County) foctory, street, office bldg., etc.) MEDI Hour o. m While Nat while ot wark ot work

p. m

21. I certify hat I attended the deceased alive an

that death accurred at

196/, that I last saw the deceased Nam the causes and an the date stated above.

ACTUAL SIGNATURE PHYSICIAN'S

NAME (Type) 22g. BURIAL, CREMATION. 22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county)

TANEY

(Stote)

JUNE18-1961 RIAL EUNERAL DIRECTOR'S SIGNATURE

REMOVAL (Specify)

ADDRESS

24b. REGISTRAR'S SIGNATURE Circhar S. Tiraus

TOWN

VS A15 (4) 15M 9/58

for

detached

pe prior

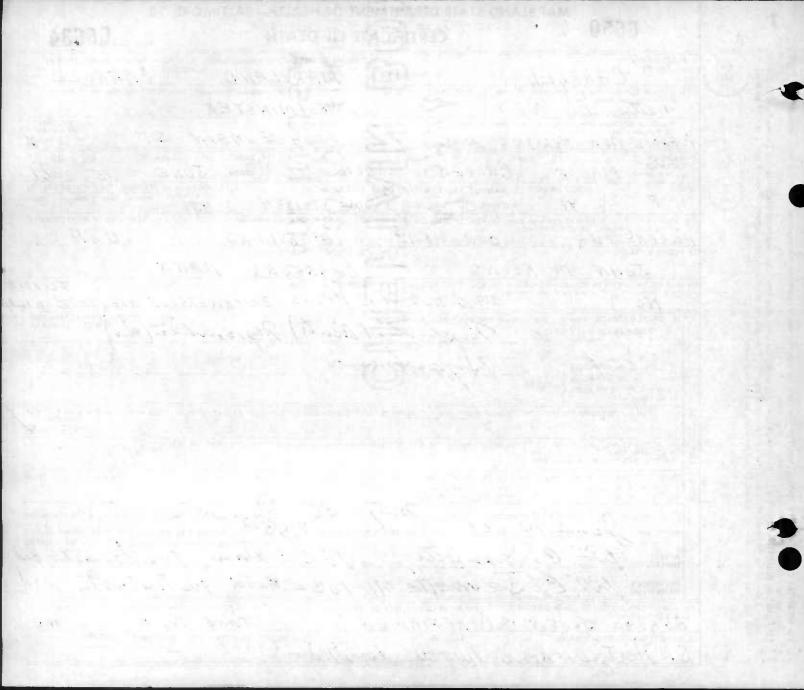
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the

FUNERAL DIRECTOR.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH							06635		
PLACE OF DEATH     O. COUNTY		MARYLAND  2. USUAL RESIDENCE (Where deceased lived. If a STATE Maryland b. CC		d lived. If instituti b. COUNTY					
b. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town)  Sykesville			mos 24d		(If autside corpo		te RURAL and give nearest town)		
OR INSTITUTION	PITAL (If not in haspital, given field State )	re street oddress)		d. STREET ADDRES					IDENCE FARM?
3. NAME OF DECEASED (Type or print)	First		Aiddle	Laviene	4. DATE OF DEATH	June			Year 19 61
s. sex <b>Male</b>	9.99 0.1	7. MARRIED NEVER A	AARRIED 3 8. ORCED 1	1892			-	AR IF UNDE	
10a. USUAL OCCUPAT during most of wo Laborer	ION (Give kind of work do rking life, even if retired)	one 10b. KIND OF 8USIN	ESS OR INDUSTR	Y 11. BIRTHPLACE (S		country)	12. CITIZEN		OUNTRY
13. FATHER'S NAME  Israel:	Lavigne			14. MOTHER'S MAID Bessie	Siegel				
1S. WAS DECEASED EV (Yes, no. or unknown) Yes. 19:	/ER IN U. S. ARMED FORCE		Y NO. 17. INFO	RMANT		Add		1917	
Conditions, if gave rise to couse (o), stoting lying couse lost	g the <u>under-</u> DUE TO (c)_		iver.					110 11/10	ALIZOBOV
C.B.S.a	THER SIGNIFICANT CONDI- SSOC. WITH CET VAS UNDERLYING [2]	rebral arter	ioscler	osis with	p sy chot	ic reacti	on.	PERFO YES A	RMED?
OR CONTRIBUTION	G CAUSE OF DEATH Y MEDICAL EXAMINER)  JRY Month, Doy, Year		D 20e. PLAC	E OF INJURY (Home, ry, street, office bldg.	form, 20f. (City		(Count	(y)	(Stote
21. I certify that (I) (this haspital) attended the deceased fram November 15,1957, to June 9, 1961, that (I) (we) last saw the deceased alive an June 8, 1961, and that death accurred at 2:45AM ram the causes and an the date stated above.									
22c. PHYSCIAN'S NAME (Type)	Agustin de	el Campo, M.I	M.	22d. ADDRESS	MED. DIRECTOR   Tield He	STAFF PHYS.   Spital, S	6, vkesvil	/9/61	b. DATE SIGNED
23a. BURIAL, CREMATI REMOVAL (Specif Buria	ON, 23b. DATE THEREOF	23c. NAME OF	cemetery or o	REMATORY	23d. LOCA	TION (City, tawn,	or caunty)	(State	
24. FUNERAL DIRECTO	Naved A	Martin 902 Eutaw	Place		REC'D BY REGIS	TRAR 2Sb. REGI	STRAR'S SIGNAT		

Poge 4 TO HOSPITAL OF TENNING PHYSICIAN: The low requires that the death certificate be executed by 24 hours often dear roge 4 may be retained the spital or ottending physician.

TO FUNERAL DIRECTOR: Fifter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours ofter death. 24 hours ofter de PHYSICIAN: The low requires that the death certificate be executed

TO HOSPITAL O

VR A1S (4) 1SM 9/S9

0.6635 Ace per little probably one by the JE Bonnet Library St. Serial Land Scriptish Section F 100 LT = 150 . To the Min of Commence of the Advantage of the Tolly and the angels . . . . A sect To a sect of the section of The state of the s Watthwest Description and Land Co. No. of the land

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

HTA

06636

25b. REGISTRAR'S SIGNATURE

a thur S. Thous

250. REC'D BY REGISTRAR

68

24. FUNERAL DIRECTOR'S SIGNATURE

The State of	 ., .,	
552	CERTIFICAT	E OF DEA

1. PLACE OF DEATH o. COUNTY Carroll	MARYLAND	2. USUAL RESIDENCE (W. o. STATE Mary.	b. COUN	tution: Residence before admission) Trederick
b. CITY OR TOWN (If outside corporate limits, RURAL and give nearest town)  Sykesville	write c. LENGTH OF STAY IN 16 30yrs.7mos.25			te RURAL and give nearest town)
d. NAME OF HOSPITAL (If not in hospital, give or institution Springfield State Ho	street oddress) spital	d. STREET ADDRESS RFD #1.		e. IS RESIDENCE ON A FARM? YES NO
3. NAME OF First DECEASED (Type or print) Heste:	Middle T	Linton	OF	une U, 1961
Towns of Library	MARRIED NEVER MARRIED TO DIVORCED DIVORCED	8. date of birth Unknown	9. AGE (In year lost but had	ors IF UNDER 1 YEAR IF UNDER 24 HRS. Months Doys Hours Min.
10a. USUAL OCCUPATION (Give kind of work dor during most of working life, even if retired) None	ne 10b. KIND OF BUSINESS OR INDU	ISTRY 11. BIRTHPLACE (Stote Maryland	or foreign country)	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME		14. MOTHER'S MAIDEN	NAME	
George Linton		Laura Er	ngle	
15. WAS DECEASED EVER IN U. S. ARMED FORCE (Yes, no, or unknown)   (If yes, give war or dates of servi		NFORMANT		Address
NO (If yes, give war or adies of servi	ce)	Springfield He	ospital Recor	ds
PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (o)  DUE TO  Conditions, if ony, which gove rise to immediate couse (a), stating the under-lying couse lost.  (c)	Arteriosclerot	ic heart dise	ase	INTERVAL BETWEEN ONSET AND DEATH Years
Schizophrenic reacti  Schizophrenic reacti  200. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING   CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	tions contributing to DEATH BU on, simple type,	t not related to the term in a mental de	inal disease condition elective.	GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO
	Db. DESCRIBE HOW INJURY OCCURRI	ED. (Enter noture of injury in	Port I or Port II of item 18.	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. 19		LACE OF INJURY (Home, farm poctory, street, office bldg., etc		(County) (State
21. I certify that (I) (this haspital) saw the deceased alive an Jun	attended the deceased frame 3, 19 61, and that	March 7, 19	AMfrom the causes	
Capriatni de	l compo		NED. STAFF PHYS.	22b. DATE 6/4/61
22/ PHYSICIAN'S NAME (Type) Agustin de	lCampo, M.D.	Springfie	ld Hospital,	Sykesville, Md.
230. BURTAL, CREMATION, 23b. DATE THEREOF	23c NAME OF GEMETERY	OR CREMATORY	23d. LOCATION (City to	wn, or county)  (Stote)

tol or ottending physicion.

this certificate has been signed by the ottending physicion and completely filled in by the funeral director, or use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with ar to burial, crematian, ar removal, and in any event, within 72 hours offer death. ar removol, TO HOSPITAL OF TEMBING PROPERTY OF THE Spirol TO FUNERAL DIRECTOR. Frier this page 3 should be detoched for usine Stote Board of Health prior to

requires that the deoth certificate be

PHYSICIAN: The low

Poge 4

n 24 hours ofter deg

VR A1S (4) 1SM 9/S9

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### MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

		000		CERTIFI	CA	TE OF DEATH	1			066	34
o. CC	CE OF DEATH DUNTY	rroll		MARYL	AND	2. USUAL RESIDENCE (Wo. STATE	Tand	ived. If instituti b. COUNTY		before o	
RU	Sykesv	ille		c. LENGTH OF STAY II		c. CITY OR TOWN (IF	outside corporo	te limits, write R	URAL ond gi	ve nearest	town)
d. N.	RINSTITUTION	AL (If not in hospitol, g				d. STREET ADDRESS 25 P	ark Ave	nue			RESIDENCE ON A FARM?
	ASED or print)	Fire Edwa	ard	Middle Gran		Little	4. DATE OF DEATH	June	th	Day 23,	Yeor 19 61
S. SEX	Male	6. COLOR OR RACE White	7. MARRIE		_	B. DATE OF BIRTH  December 1	4, 1883	AGE (In years lost birthdoy) 77 yrs.			JNDER 24 HR purs Min.
0a. USI dur	ing most of work	ON (Give kind of work or ing life, even if retired)  ng store	lone 10b. K	IND OF BUSINESS OR	INDUS	TRY 11. BIRTHPLACE (Stot		ntry)		S.A.	HAT COUNTRY
3. FATH	Georg	ge Little				14. MOTHER'S MAIDEN	beth Ho	uck			
(Yes, no.		R IN U. S. ARMED FOR (If yes, give wor or dates of se		OCIAL SECURITY NO.		FORMANT pringfield H	ospital	Records			
g c co lyi	3345 onditions, if or over ise to it use (o), stoting ng couse lost.	the <u>under-</u> DUE TO				chopneumonia			(Fall b) 9 A DT	De	AND DEATH
STIFICA SOG	. ACCIDENT WA					NOT RELATED TO THE TER/ 1 OS CLE POSIS •			VEN IN PARI	YE	S NO
WEDICAL	TIME OF INJUR Hour o. m. p. m.	Y Month, Doy, Yea	20d. IN. While of work	Not while	20e. PLA foc	CE OF INJURY (Home, fai tory, street, office bldg., e	rm, 20f. (City o	r town)	(Ca	ounty)	(Stot
sav	w the deceas					April 24, 1					
95	PHYSICIAT'S	ustri co	lel	Campo	,		MED. DIRECTOR	STAFF PHYS.			22b. DATE 6/23/6
23o. BUI	NAME (II Ine)	n, 23b, DATE THEREO		M.D.  23c. NAME OF CEME	TERY OI	Springfie		Ital, Syl		le,Mo	(Stote)
21. FUN	FRAL DIRECTOR	S SIGNATURE	11/0	ADDRESS	te.	250. RE	SIP 2 PEGISTR		STRAR'S SIG		, m

may be revain.

TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, ar remayol, and in any event, within 72 haurs after death. TO HOSPITAL OF VR A1S (4) 1SM 9/S9

n 24 hours ofter de

NG PHYSICIAN: The low requires that the deoth certificate be executed

医疗会员 58333 COMPANY ATOMATIC The send of the same of - 1 Feb 3 50 11 affiliation with The second State at Lat. No ext. Till. The state of the s The state of the s The second of mides THE STATE OF THE S

VR A15 (4) 15M 9/S9

# MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

6	654	10 NOI	CERTIFICA	TE OF DEATH		MARTLAND	(	066	38	
1. PLACE OF DEATH	rroll		MARYLAND	2. USUAL RESIDENCE (V		ed lived. If institution b. COUNTY	on: Residence	before o	dmissio	on)
b. CITY OR TOWN (	If outside corporate lim	its, write	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (IF		orate limits, write R	URAL ond gi	ve neares	t tawn)	
RURAL and give n			2ly-llm-ld.	Balt	imore			3 V	(	21
Rural) Syke	TAL (If not in hospital,	give street	oddress)	d. STREET ADDRESS	. 101	28-21	450	e. I	S RESIL	DENCE
OR INSTITUTION	eld State	Toeni	tal	2000	5 E. F.	airmount	Ave.		ON A I	NO 🗍
3. NAME OF DECEASED	Fi	rst	Middle	Last	4. DATE	Mon		Day	Y	eor
(Type or print)	John			Meerdter	DEATH	0		- 8		961
5. SEX	6. COLOR OR RACE	7. MAR	RIED NEVER MARRIED	B. DATE OF BIRTH		9. AGE (In years lost birthdoy)	Manths D		UNDER lours	R 24 HRS Min.
male	white	WIDOW	ED DIVORCED	7-18-1886	100	/7574 yrs.	I Wild will be	2075	0013	741111.
10a. USUAL OCCUPATION during mast of wor	ON (Give kind of work king life, even if retired	done 10b.	KIND OF BUSINESS OR INDU	JSTRY 11. BIRTHPLACE (State	le ar foreign	country)		EN OF W	HATCO	DUNTRY
Laborer				Maryland			U	JSA		
13. FATHER'S NAME				14. MOTHER'S MAIDEN	NAME					
John Me	erdter, Sr.			Annie Ku	fman					
15. WAS DECEASED EVE	R IN U. S. ARMED FO	RCES? 16.	SOCIAL SECURITY NO. 17.	NFORMANT		Add	ress	1 74	-	
(Yes, no, or unknown) unknown	(If yes, give war or dates of		nknown	Hospital Reco	ords					
IB. CAUSE OF DEA	ATH [Enter only one o	ouse per li	ne for (o), (b), and (c).]	*				INTERV	AL BET	WEEN
	TH WAS CAUSED BY:		onary Occlusio	on				ONSET	MIL	DEATH 111 te
00	3 DUE TO	1					-3-1-1	-		
Canditians, if a			vous System Sy	mhilis				VE	ars	
gave rise to i	mmediate	)	TOUR BY BOOK!	, p				3	7000, 6	
couse (o), stoting		AY	teriosclerosis	3				770	2020	
lying couse lost.		c)(c)			MINIAL DICCA	SE CONDITION ON	/ENI INI DART		ears	
2 Chronic	brain syn	irome	CONTRIBUTING TO DEATH BU	th central h	ervous	system	EN IN PARI	(d) 17.	ERFOR	MED?
⊴ syphil			ular with psyc					YI	ES 🗌	NO [
Chronic syphil 20%. Accident w. Contribution (IF EITHER, NOTIFY	AS UNDERLYING  CAUSE OF DEATH MEDICAL EXAMINER)	20b. DES	CRIBE HOW INJURY OCCURR	ED. (Enter noture af injury i	n Part I or Po	ort II of item IB.)				
	RY Month, Doy, Ye	or 20d I	NJURY OCCURRED 20e. P	LACE OF INJURY (Home, fa	rm 206 (Ci	ty or tawn)	ICI	ounty)		(State
ZOc. TIME OF INJUI Hour o.m. p.m.	19	While at wo	_ Not while _ fo	octory, street, office bldg., e		,, 0, 10, 11,	100	,0,,,,	7	(Sidire
21. I certify the	at (1) (this haspita	1) attend	ded the deceased fram.	July 1	253 ta.	June	8, 196	1, that	(l) (v	ve) las
			19_61 and that		138/				. , .	,
22d. SIGNATURE										DATE
HYUP	Lon thi	AGS	ROBR/	M.D. PHYS.	MED. DIRECTOR	STAFF 75			6/8	SIGNE
22c. PHYSICIAN'S		1	X	22d. ADDRESS					2/1	ef Solda.
NAME (Type)	Myron Niza	nkows	sky, M.D.	Spri	ngfiel	Ld State I	Hospita	al		
23a. BURIAL, CREMATIC			23c. NAME OF CEMETERY	OR CREMATORY	23d. LOC/	ATION (City, town,	or county)	,	(Stote	e)
REMOVAL (Specify		61	Meadowaldg	M D	00	cudge	m	9	131016	,
24. FUNERAL DIRECTOR			ADDRESS	2Sa. RE	C'D BY REGIS	STRAR 25b, REGI	ISTRAR'S SIG	NATURE		
INOMAS	V. KRNI	141	NU BARTO	- MG DATE!	UN 14'	61 Ch	Must S. 1	Kraus		

~ 1 CONTRACTOR OF STREET and the state of the particle of the state o Signal State of the second de la company de 

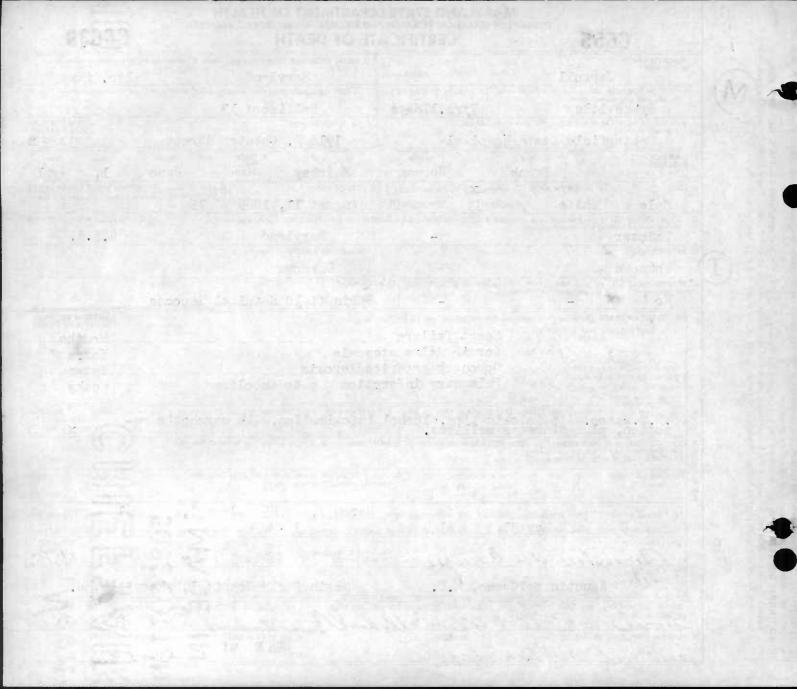
# TO HOSPITAL OF STENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after de page 4 may be retain it spital as attending physician. TO FUNERAL DIRECTOR: Ster this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remave carban pages. Pages 1 and 2 shauld be filed with the State Board of Health priar to burial, cremation, as remaval, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

### 6655

# MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

1	. PLACE OF DEATH o. COUNTY	arroll		MARYL	AND	2. USUAL RESIDENCE (Va. STATE	Where deceased	l lived. If institution b. COUNTY		before odm	
	b. CITY OR TOWN (If RURAL ond give nec Sykesv	arest town)	ts, write	c. LENGTH OF STAY II		c. CITY OR TOWN (I	f outside corpor		JRAL ond giv	ve nearest to	(wn)
	d. NAME OF HOSPITA OR INSTITUTION Spring	AL (If not in hospital, g				d. STREET ADDRESS 1916 N.	Cheste	r Street		ON	ESIDENCE A FARM?
3	NAME OF DECEASED (Type or print)	Fira Fra		Middle Herman	ı	Meickey	4. DATE OF DEATH	Mon Jur		Day 1.	Year 1961
5	. sex Male	6. COLOR OR RACE White	7. MARR	DIVORCED		DATE OF BIRTH August 11	, 1885	9. AGE (In years lost birthdoy) 75 yrs.		YEAR IF UN	IDER 24 HRS.
1	Oa. USUAL OCCUPATION during most of working Painter	N (Give kind of work on the life, even if retired	done 10b.	KIND OF BUSINESS OR	INDUST	RY 11. BIRTHPLACE (Sto		ountry)		U.S.A.	T COUNTRY?
Ji	3. FATHER'S NAME				34.	14. MOTHER'S MAIDEN	NAME				
	Unknown					Unknow	a				
	5. WAS DECEASED EVER			SOCIAL SECURITY NO.	17. INF	ORMANT		Addr	ess		
1	(Yes, no, or unknown) (I	If yes, give war or dates of s	ervice)		5	Springfield	Hospit	al Record	ds		
		TH [Enter only one co TH WAS CAUSED BY: IMMEDIATE CAUSE (o		e for (a), (b), ond (c).]						INTERVAL ONSET AN	ND DEATH
1	LLO	DUE TO		ortic valve		nosis				Monti	
	Conditions, if on	v. which		oronary arte						Years	
	gave rise to im cause (o), stating t lying cause lost.	mediote (				tion due to	emboli	sm		Weeks	4
100	C.B.S. ass	er significant con oc. with in plus diabe	toxic tes m	ontributing to DEA ation, alcohellitus.	101 TOI	or RELATED TO THE TER Intoxication	minal disease n, with	conduion GIV psychoti	EN IN PART	1(a) 19. WA PER YES	S AUTOPSY FORMED?
-	20a. ACCIDENT WAS OR CONTRIBUTING (IF EITHER, NOTIFY A	S UNDERLYING  CAUSE OF DEATH				(Enter nature of injury				43	
0.00	20c. TIME OF INJURY Haur o. m. p. m.	Month, Doy, Ye	ar 20d. IN While of worl	Not while		CE OF INJURY (Home, forry, street, office bldg.,		or town)	(Co	unty)	(Stote)
		(I) (this haspitoled alive on May	) ottend	ed the deceosed f	rom!	March 7,	AMM, from				) (we) last
1	22a. SIGNATURE	stris de		unpo			MED. DIRECTOR	STAFF PHYS.			22b. DATE SIGNED
	22c. PHYSICT (N'S NAME (Type)	Agustin de	-			22d. ADDRESS Springfie	eld Hos	pital,Syl	cesvil	le,Md.	
2	Ga. BURIAL, CREMATION REMOVAL (Specify)	N. 23b. DATE THEREC	961	23c. NAME OF CEME	TERY OR	CREMATORY	23d LOCAT	TION (City, town,	or county)	ello	tote)
2	4. FUNERAL DIRECTOR'S	SIGNATURE	Tern	ADDRESS Off the		250. RE	UN 6 6	1	STRAR'S SIGI		



_										
	Carrol	1	MARYLAND	2. USUAL RESIDENCE (WI			imore City			
	RURAL and give ne		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If o	1022	nits, write RURAL	ond give nearest tawn)			
-	Sykesvil		6 mos. 26 da			2 V	e. IS RESIDENCE			
	OR INSTITUTION	AL (If nat in hospital, give street	address)		ON					
	Springfi	eld State Hospi	tal	308 Dalla	s Court		YES NO 🛣			
3.	NAME OF	First	Middle	Lost	4. DATE OF	Manth	Day Year			
	DECEASED (Type or print)	Mary	Emma	Meyers	DEATH	June	14 1961			
5. 5	SEX	6. COLOR OR RACE 7. MARR	HED NEVER MARRIED	B. DATE OF BIRTH	9. AC		NDER 1 YEAR IF UNDER 24 HRS.			
	Female	White WIDOW	DIVORCED	7-20-82	103	78 yrs. Mor	oths Days Haurs Min.			
10a	USUAL OCCUPATIO	N (Give kind af work dane 10b.	KIND OF BUSINESS OR IND	USTRY 11. BIRTHPLACE (State	ar fareign country)	1:	2. CITIZEN OF WHAT COUNTRY?			
	Hosewife	ng life, even if retired)	<b>→</b> *	Maryla	nd		U.S.A.			
13.	FATHER'S NAME			14. MOTHER'S MAIDEN I						
	William E	lliott		Sarah Wil	lliams					
15.	WAS DECEASED EVER	IN U. S. ARMED FORCES? 16.	SOCIAL SECURITY NO. 17.	INFORMANT		Address				
(Yes	No (	f yes, give wor or dates of service)	2-05-8483D	Springfield H	Hospital	Records				
	18. CAUSE OF DEA	TH   Enter anly one cause per lin	ne far (a), (b), and (c).]				INTERVAL BETWEEN			
		H WAS CAUSED BY: Mas	ltiple infect	ed hed sores			ONSET AND DEATH			
	1150	William Colone	TOTPIC TIMOOC	, od bod box ob						
	450.0	DUE TO	lnutrition				months			
	Conditions, if an		THUCLICION				MOHOLIS			
	couse (a), stoting t	he under- DUE TO								
	lying cause lost.	(c) ge	neralized art	eriosclerosis	marked.		years			
Z	PART II. OTH	er significant conditions of	CONTRIBUTING TO DEATH BE	JT NOT RELATED TO THE TERM	INAL DISEASE CON	IDITION GIVEN IN	PART 1(o) 19. WAS AUTOPSY PERFORMED?			
CERTIFICATION	C.B.S.	associated wit	h cerebral ar	teriosclerosis	with ps	ychotic	reaction   NO NO			
I F	20a. ACCIDENT WA	S UNDERLYING [] 20b. DES		RED. (Enter nature of injury in			NI-O DESCRIPTION			
	(IF EITHER, NOTIFY	CAUSE OF DEATH MEDICAL EXAMINER)								
MEDICAL	20c. TIME OF INJURY	Manth, Day, Year 20d. II		PLACE OF INJURY (Hame, farm		wn}	(County) (State)			
ED	Haur a.m.	19 While at war	IAGI AUIE	factary, street, affice bldg., etc	:-}					
2	p. m.			37 34 /	(O Tour	- 7/	63			
	21. I certify that	(I) (this haspital) attend	led the deceased from	Nov. 18 19	ou_ ha Jun	0 14	19.61, that (I) (we) last			
	saw the deceas	ed alive an June 1/	1961, and that	death accurred at	A, from the	causes and ar	n the date stated above.			
	22a. SIGNATURE	4. 0	101	. week in this			22b. DATE SIGNED			
	1/2	melni de	Chm/20	M.D. ATTENDING M	IRECTOR PH	AFF YS. <b>*</b>	6-14-61			
1	22c. PHTSICIAN			22d. ADDRESS						
	NAME (Type) Agusti	n del Campo, M.	D.	Springfie	ld State	Hospital	, Sykesville, N			

23c. NAME OF CEMETERY OR CREMATORY

9015, CONSLING ST. BALTO, 24, MD.

MT. CARMEL CEM

certificate has been signed by the ottending physician and campletely filled in by the funeral director, e as the burial-transit permit. Then please remave carbon papers. Pages 1 and 2 should be filed with PHYSICIAN: The law requires that the death certificate be executed TO FUNERAL DIRE
poge 3 should be
the State Board o TO HOSPITAL VR A1S (4) 1SM 9/S9

ers. Pages 1 after death.

6656

23a. BURIAL, CREMATION, REMOVAL (Specify)

24. FAINERAL DIRECTOR'S SIGNATURE

23b. DATE THEREOF

250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUN 1 9 '61 DATE

23d. LOCATION (City, town, ar caunty)

57/20 DONNELL

arthur S. Krous

, Md.

(Stote)

washing the county the first them Smith for a form Poul III (2) 2 Create Contract The same that because it applies to the property of the same of A least friend of ordinary life of the time of the street, and Marietan Ald Chrophy or a grant of the THE WALL SELL AT SHARE DEATH WEIGHT WILLIAM SHARE IT SHE SHARE THE

### MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) y is necessary. Idirector. Page for your files. a. COUNTY b. COUNTY MARYLAND b. CITY OR TOWN (if outside corporete limits, c. LENGTH OF STAY IN 16 CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) grite RURAL and give nearest town. for your Board of thupflered VELLA. d. NAME OF HOSPITAL OR INSTITUTION (if not in trospital, give street address) d. STREET ADDRESS 3 to the funeral retained he State B 3. NAME OF Middle DATE Dey 4. Month DECEASED (Type or print) DEATH 62616 9 with 6. COLOR OR RACE 7. MARRIED X NEVER MARRIED DATE OF BIRTH AGE (in years | IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. may 2 wit ss 1, 2, and 3 Page 5 may 1 and 2 will last birthday) Months Days WIDOWED DIVORCED be executed within 24 hours after encil in hem 18. Give Pages 1, 2, a e along with form PM3. Page 5 r 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 11. 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) 1025 pages 1 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME with form F permit. File File ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unkown) (Ifyesgivewarordalesofservice) 18. CAUSE OF DEATH [Enter only one cappe per line for (a), (b), and (c). Office along v burial-transit p INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) in pencil Examiner's Office be used as a burial-hation, or removal, DUE TO certificate should Conditions, if any, which (b) "pending" gave rise to immediate cause DUE TO (a), stetling the underlying cause lest. Medical Examir should be used rial, cremation, be used PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 19, WAS AUTOPSY CERTIFICATION writing the word 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED. (Enler nature of injury in Pert I or Part II of item 18.) PRIMARY OF CONTRIBUTING Chief Me age 3 sho to burial, the Chie 20c. TIME OF INJURY 20e. PLACE OF INJURY (Home, farm, Month, Day, Year 20d. INJURY OCCURRED 20f. (City or town) (County) factory, street, office bldg., etc.) 0 While Not While 10:30 (1) 20 1961 at work at work icale, prior should be forwarded to the FUNERAL DIRECTOR: 21. I certify that I took charge of the remains described above, held an Autopsy Inspection V. Inquiry and in my opinion agent, death resulted from: Natural causes Accident Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER designated ACTUAL ASSISTANT MEDICAL EXAMINER DATE SIGNED please execute SIGNATURE DEPUTY MEDICAL EXAMINER DEPUTY EXAMINER'S NAME (Type) Address (Streat, city, town, or county) Was luce 22a, BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or country) S REMOVAL (Specify) OH 40 ROLLLOTLIL FUNERAL DIRECTOR ADDRESS 24a. REC'D BY REGISTRAR I 24b. REGISTRAR'S SIGNATURE

VS. A15ME

5M 7/59

e. IS RESIDENCE ON A FARM?

YES NO

PERFORMED?

NO

(Slale)

ne

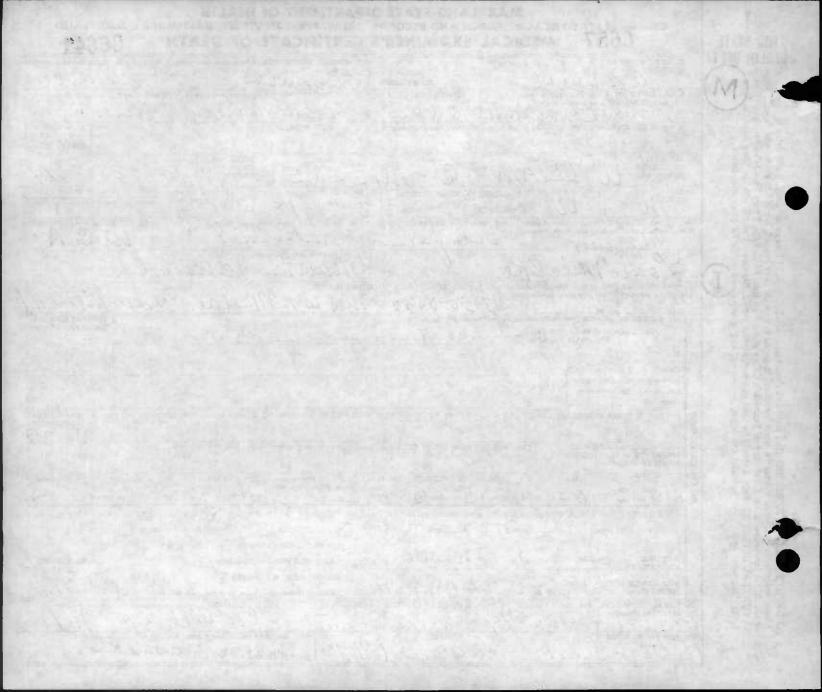
(Slate)

arthur S. Kraus

DATEJUN 21

Min.

Hours



in any event, within 72 haurs after death

### MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1	0	5	6	4	2
- 1	J 1	0	0	3	6.1

	6658
1. PLACE OF DEAT	TH C

Carroll MARYLAND 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY Maryland

Carroll

	c. LENGTH OF STAY IN 16	c. C	ITY OR TOWN (	lf autside car	porate limits, write RURAL a	nd give ne	arest town)
Sykesville	lyr.llmos.9days	X	Crowel	Town,	Westminster,	Gen.	Deli
A NAME OF HOSPITAL (If not in hospital give street			TREET ADDRESS	-			a IS PESIT

7 Tom Wastmington Con

b. COUNTY

Sykesv:	TITE	TAL. TIMOS	.ydays	CLOMET	T OWIL,	Wesummis	er,	dell.	Der.	rverl
	PITAL (If nat in haspital, give	street address)		d. STREET ADDRESS					e. IS RESI	
Spring	field State He	ospital		None	B 1					NO 🔀
. NAME OF	First	M	iddle	Lost	4. DATE	Man	th	Da	y Y	'ear
(Type ar print)	Alice	Mary Mille	er	Miller	DEATI	4 June	3	20,	1	9 61
5. SEX	6. COLOR OR RACE 7	MARRIED NEVER M	ARRIED 🔲	B. DATE OF BIRTH		9. AGE (In years last birthday)	IF UNDER		-	
Female	White w	IDOWED DIVE	DRCED 🗌	July 5, 18	380	80 yrs.	Manths	Days	Haurs	Min.
100. USUAL OCCUPA	TION (Give kind of work do	ne 10b. KIND OF BUSINE	SS OR INDU	STRY 11. BIRTHPLACE (Stat	te ar fareign	country)	12. CIT	IZEN OF	WHATC	OUNTRY?
Housewi	_ ,		_	Maryla	and			U.S	.A.	
3. FATHER'S NAME			- 10	14. MOTHER'S MAIDEN	NAME					
Elie Mi	ller			Lavina M	farkle					
	VER IN U. S. ARMED FORCE		NO. 17.11	NFORMANT		Addi	ess			Total
No	(if yes, give wor or acres or servi	ce)		Springfield	Hospi	Ital Recon	rds			
-	DEATH [Enter anly ane cause	per line far (a), (b), and	(c).]						RVAL BET	
PART I. C	DEATH WAS CAUSED BY:	Infected 1	oed so	ores:				40.4	eeks	DEATH
28615	DUE TO		The state of				O. O. C.			
Canditians, if	fany, which ) (b)_	Malnutriti	ion					M	onth	S
gave rise to cause (a), statis	immediate (						11.20		Line	
lying cause la						J. Partin				
C.B.S.a	other significant condissoc. with sen	ile brain d	DEATH BUT	with psychot	MNAL DISEA	SE CONDITION GIV	EN IN PAI	RT 1(a) 1	9. WAS A PERFOR	AUTOPSY RMED? NO
(IF EITHER, NOT	WAS UNDERLYING   20 NG   CAUSE OF DEATH IFY MEDICAL EXAMINER)	Db. DESCRIBE HOW INJU	RY OCCURRE	D. (Enter nature af injury in	n Part I ar Po	art 11 of item 18.)				
20c. TIME OF INJ Haur a. r p. r	m. 10	20d. INJURY OCCURRED While Nat while at wark at at wark		ACE OF INJURY (Hame, far ctary, street, affice bldg., e		ty ar tawn)		(Caunty)		(State)
21. I certify t	hat (I) (this haspital)	attended the deced	ised fram		9.59 ta	June 20	, 19	61, th	at (I) (v	ve) last
	eased alive an Jun	e 20, 19 OL,	and that a	death accurred at	M, fran	n the causes an	d an th	e date		
22a. SIGNATURE	anti-	0000	.h.		MED.	STAFF			6/07	SIGNED
EZC. PHYSICAN	men a	a com	Jec	M.D. PHYS.	DIRECTOR L	PHYS.			0/57	/61
EXC. FILISION	3		/	ZZG. ADUKESS						

Agustin delCampo, M.D.

Springfield Hospital, Sykesville, Md.

BURIAL, CREMATION, 23b. DATE THEREOF

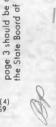
23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, tawn, ar caunty)

PUNEPAR DIRECTOR'S SIGNATURE

95a. REC'S BY REGISTRAR 3 '61 25B. REGISTRAR'S SIGNATURE

may be retain TO FUNERAL DIR VR A1S (4) 1SM 9/S9



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6659

# MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

06643

1. PLACE OF DEATH a. COUNTY	Carroll		MARYLAND	II o STA	TE	here deceased	lived. If institution b. COUNTY	D	efare admiss	V
b. CITY OR TOWN RURAL and give	(If autside carporate lim	its, write c. LENC	GTH OF STAY IN 16	c. CIT			ate limits, write RU			
Sykesvi		38yr	s.4mos.22	days	Balt	timore		3 VO1-4	1	
d. NAME OF HOSE OR INSTITUTION	PITAL (If not in haspital,			d. STI	REET ADDRESS	2 Suffo	lk Ave.			FARM?
3. NAME OF DECEASED (Type or print)	Fi	ompson	Middle	1	Miller	4. DATE OF DEATH	June	18	Day	Year 19 61
s. sex Male	6. COLOR OR RACE White	7. MARRIED N	NEVER MARRIED TO	Feb.	all a		9. AGE (In years last bathday) 61 yrs.	Months Day	AR IF UNDE	
10a. USUAL OCCUPAT during mast of we Druggis	ION (Give kind of work prking life, even if retired to CLERK	1)	BUSINESS OR INC		RTHPLACE (Stone		untry)		S.A.	OUNTRY
13. FATHER'S NAME					HER'S MAIDEN	NAME				
accaptack	obooMbbben:	J. Thomps	son Mille	r. Sr. A	nnie O'N	leal				
15. WAS DECEASED EN	ER IN U. S. ARMED FOI	RCES? 16. SOCIAL		INFORMANT			Addre	55		
(Yes, no or unknown)	(If yes, give war or dates of	service	All rains		Springfi	ield Ho	spital Re	cords		
	EATH [Enter anly one of EATH WAS CAUSED BY: IMMEDIATE CAUSE (c	CA:	of L	ING	3			0	NTERVAL BE	TWEEN DEATH
Condition If								1000		
Canditians, if	immediate (									
cause (a), statin										
_	THE SOUTH CANTES	otion, pa	TING 19 SEATH	pe.	TED TO THE TERM	MINAL DISEASE	CONDITION GIVE	N IN PART 1(a		AUTOPSY ORMED?
200. ACCIDENT V	VAS UNDERLYING [] IG [] CAUSE OF DEATH FY MEDICAL EXAMINER)	20b. DESCRIBE HO	OW INJURY OCCUR	RED. (Enter no	lure of injury in	Part I ar Part	II af item 1B.)			
20c. TIME OF INJU Haur a. m p. m	10		nt while		URY (Hame, far , affice bldg., et		ar tawn)	(Caun	ty)	(State
	nat (I) (this haspita ased alive an Jur	1) attended the ne 17, 19	deceased fram	n. Marcl	1 7 , 19	AM fram t	une 18, the causes and	, 19 <b>61</b> I an the do	that (I) ( ate stated	we) las
22a. SIGNATURE	istin a	lef Co	mpo	M.D. ATTE	NDING .	MED. DIRECTOR [	STAFF PHYS.		6/2	b. DATE SIGNE 18/6
22c. PHYSIC AN'S NAME (Type)	Agustin de	lCampo, M	.D. //		ADDRESS Springfi	Leld Ho	spital,Sy	kesvil	le,Md	•
23a. BURIAL, CREMAT REMOVAL (Specif Cremation		OF 23c. N	AME OF CEMETERY		ory ematory		ION (City, tawn, ar l timore,		(Stat	le)
24. FUNERAL DIRECTO	7	MAS	DRESS Q	at at A		D BY REGISTR		RAR'S SIGNA		11.8
Ikm ( Leck	kner 12 Deal	· corg	MO FIL	2 Wil	DATE N	IUN 21 '6	il Cin	Muy & h	anni	

TO HOSPITAL OF TENDING PH may be retain the spiral of TO FUNERAL DIRECTOR: Where this page 3 shauld be detached for us the State Board of Health prior to VR A15 (4) 15M 9/S9

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AND THE PROPERTY OF THE PROPER				
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	E Brown and	erather than the		

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06644

Ľ	Carroll		CHI-L	MARYL.	AND	2. USUAL RESIDENCE (WO. STATE Maryland	here decease	b. COUNTY	on: Residen			ion)
	<ul> <li>CITY OR TOWN (If RURAL and give ne</li> </ul>	outside corporote limi orest town)	ts, write	c. LENGTH OF STAY II		c. CITY OR TOWN (If	outside corpo	orote limits, write R	URAL ond g	give near	rest town	)
S	ykesville,	Maryland AL (If not in hospitol, g		1 mo. 26	days	Baltimore	1, Ma	ryland	3	Voi	1-4	
						d. STREET ADDRESS					. IS RES	IDENCE FARM?
		State Hos		L		806 W. I	ombard	Street			YES	NO I
	NAME OF DECEASED (Type or print)	Fir	ank	Middle		Lost	4. DATE OF	Mor	,	Day		reor -
S. S						Milunaitis	DEATH		6	16		1961
3. 3	Male	White	WIDOWI	RIED NEVER MARRIED  ED DIVORCED		2-17-97		9. AGE (In years lost birthdoy) 64 yrs.	Months	Doys	Hours	Min.
10o	. USUAL OCCUPATIO	N (Give kind of work o	one 10b.	KIND OF BUSINESS OR	INDUST	RY 11. BIRTHPLACE (Stote	e or foreign c	ountry)	12. CITI	ZENOF	WHATC	OUNTRY?
H	Tailor	ing life, even it fefired;		_		Lithuani	Я		T 5 1	thua	nio	
13.	FATHER'S NAME					14. MOTHER'S MAIDEN			177	uua	пла	4
	John Milun	aitis				Anna Lu	shikau	skas				
1S.	WAS DECEASED EVER	IN U. S. ARMED FOR	CES? 16.	SOCIAL SECURITY NO.	17, INF	DRMANT		Add	ress	-		
1103	No	if yes, give war or dates of se	2	14-30-6899	1	pringfield	Hospit	al Recor	ds			
MEDICAL CERTIFICATION	Conditions, if on gove rise to im couse (o), storing t lying couse lost.  PART II. OTHI  20a. ACCIDENT WAS OR CONTRIBUTING (IF EITHER, NOTIFY A	H WAS CAUSED BY: IMMEDIATE CAUSE (o  DUE TO  y, which he under  ER SIGNIFICANT CONI	Fa-	CONTRIBUTING TO DEAT	TH BUT N CT101 CURRED.	OT RELATED TO THE TERM  (Enter noture of injury in E OF INJURY (Home, forry, street, office bidg., etc.)	AINAL DISEAS	E CONDITION GIV		y	PERFO	DEATH
ME		(I) (this haspital	at worl	k □ ot work □ □ □		4-20, 19 ath accurred at 2:						
1-	229 SIGNATURE	Rad	Syl	Rause	Ž.M.	ATTENDING M	AED.	STAFF PHYS.	d dil ilic	dore	22b	DATE SIGNED 16-6]
	The Physician's NAME (Type)	ulian Radz	ykewy	7CZ		22d. ADDRESS Spring	field	State Ho	spital	., S	ykes	
E	BURIAL, CREMATION REMOVAL (Specify)	JUNE 20	1961	MesTHOLY	ERY ON	DEEMER	BEL	ION (City, town,	1//	ARY	(Stote	
24	osles W. A	acherest	las	-637 Wa	she	19 250. REC	D BY REGIST		STRAR'S SIG			

may be retained the spiral or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 shauld be detached for use as the burial-transit permit. Then please remove carban papers. Pages 1 and 2 shauld be filed with the State Board of Health priar to burial, cremation, or removal, and in any event, within 72 haurs after death.

TO HOSPITAL

VR A1S (4) 1SM 9/S9

- 11373 

	1		ゼ
Page 4	director.	filad with	**
TO HOSPITAL OF STTENDING PHYSICIAN: The low requires that the death certificate be executed hin 24 haurs after de Page 4	may be retain the spital or attending physician.  TO FUNERAL DIRECTOR feet this certificate has been staned by the attending physician and campletely filled in by the funeral director.	none 3 charild be detained for use as the hurinistransit permit Then please somme carbon pages. Page 1 and 2 charild be filed with	200
hin 24 hau	tely filled in	Pone 1 an	200
be executed	and cample	thon papers	er death.
certificate t	na physician	on annual e	72 havrs off
hat the death	by the attend	Then plans	event within
w requires t	sician.	ronsit permit	I, and in any
CIAN: The to	ttending phy tificate has b	the burialst	n, or remaya
DING PHYSI	spital ar a	ned for use of	rial, crematia
OF ATTEN	DIRECTOR	Id be detact	priar ta bur
TO HOSPITAL	may be retain the spital ar attending physician.  TO FUNERAL DIRECTOR. Ter this certificate has been significant.	none 3 show	the registrar priar ta burial, crematian, or remaval, and in any event within 72 haurs after death.

VS A15 (4) 15M 10/57

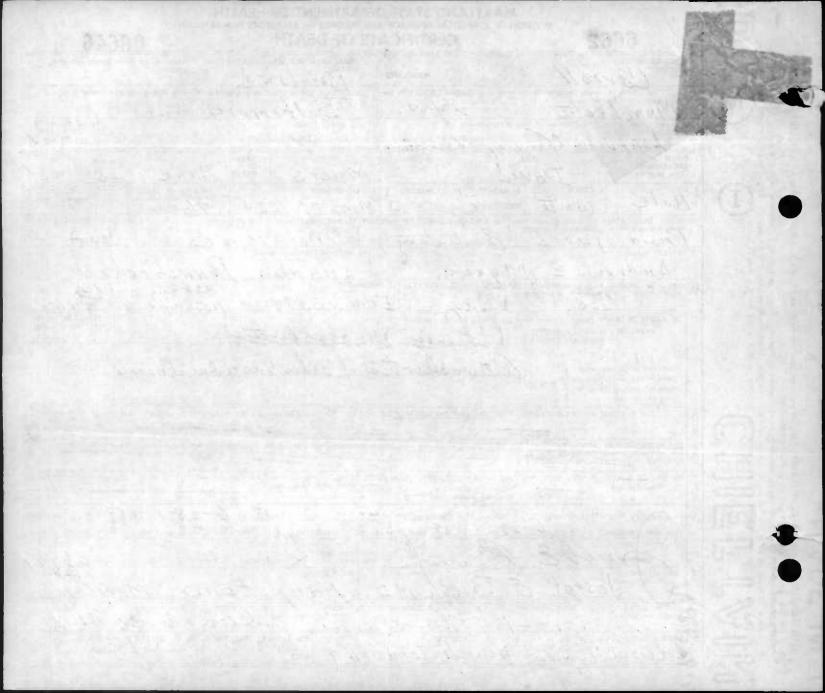
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6661 **CERTIFICATE OF DEATH** 

	$\vdash$		Nog. Dist.	110		
1	1.	PLACE OF DEATH O. COUNTY  ARROLL  MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence o. STATE b. COUNTY			
/		b. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town)	c. CITY OR TOWN (If outside corporate limits, write RURAL and give			
WESTMINSTER VERIS XWESTMINSTER						
,		d. NAME OF HOSPITAL (If not in hospital, give street ordress) OR INSTITUTION	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM?		
		RURILL	RURAL	YES NO		
	3.	NAME OF First Middle DECEASED Middle	Lost 4. DATE Month	Day Yeor		
		(Type or print) ALVERDA S. MOR	ELOCK DEATH JUNE 1	1-1961		
	5.	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED	8. DATE OF BIRTH 9. AGE (In years IF UNDER I lost birthdoy) Months D			
	1	EMALE WHITE WIDOWED DIVORCED	MAY 17-1882 79 yrs. MONTHS	loys Haurs Min.		
	10a	USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRING MOST of working life, even if retired)	STRY 11. BIRTHPLACE (Stote or foreign country) 12. CITIZ	EN OF WHAT COUNTRY?		
	1	HOUSEKEEDER AT HOME	MARVLAND /			
	13.	FATHER'S NAME	14. MOTHER'S MAIDEN NAME			
)	_	JONAS NEUNECKER	CATHERINE RAPNHA	1 PT		
1			NFORMANT Address	17		
	1,10	s. no. or unknown) (If yes, give wor or dates of service)	KIMARELAAK WESTAMINET	-= PM		
		1B. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]	THE TOTAL PROPERTY OF THE STATE	INTERVAL BETWEEN		
		PART I. DEATH WAS CAUSED BY:	Ation 10 is a way	ONSET AND DEATH		
		HAMBOIATE CAUSE (6) CO COMPANY (A	our xeckerse	0 0		
		Conditions, if ony, which ) the Van Ala Bay	1010	Sermy		
		gove rise to immediate	- Comme	years		
		lying cause lost.				
	Z	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1	I(n) 19. WAS AUTOPSY		
	CATION	none		PERFORMED? YES NO		
)	CERTIFI	206. ACCIDENT WAS UNDERLYING   20b. DESCRIBE HOW INJURY OCCURRED OR CONTRIBUTING   CAUSE OF DEATH	D. (Enter noture of injury in Port I or Port II of item 18.)			
		(IF EITHER, NOTIFY MEDICAL EXAMINER)				
	MEDICAL		ACE OF INJURY (Home, form, 20f. (City or town) (Cortory, street, office bldg., etc.)	unty) (Stote)		
	MED	Hour o. m. While Not while ot work ot work	story, street, office blogs, etc.)			
		21. I certify that I attended the deceased from New 104	, 1960, ta fring 210, 1961, that I lo	st saw the deceased		
		alive on June 19 , 19 4 / , and that death	accurred at 90 A M, fram the causes and an the	date stated above.		
		A 23 4	ADDRESS (Street, city or town, stote)	DATE SIGNED		
		SIGNATURE O Billimalen	M.D. Westminuter	hid. 4-23-0		
		PHYSICIAN'S				
		NAME (Type) _ C 1 4. 131/1/17 95/ C 4	WESTMINSTER	MA		
	220	BURIAL, CREMATION, 22b. DATE THEREOF 22g. MAME OF CEMETERY OF	R CREMATORY 22d. LOCATION (City, town, or county)	(Stote)		
1	1	SURIAL 10/24/6/ WEISTERS	CEIM. WESTMINSTER	R.D. MA		
	25	FUMERAL DIRECTOR'S SISNATURE ADDRESS	24g, REC'D BY REGISTRAR 24b, REGISTRAR'S SIGN	ATURE		

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS - BALTIMORE 1, MARYLAND 6662 CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) PLACE OF DEATH COUNTY b. COUNTY MARYLAND b. CITY OR TOWN (If outside carparate limits, write c. CITY OR TOWN (If autside carparate limits, write RURAL and give negrest town) c. LENGTH OF STAY IN 16 RURAL and give nearest town City, Maryland d. NAME OF HOSPITAL (If not in hospital, give street address) e. IS RESIDENCE d. STREET ADDRESS ON A FARM? OR INSTITUTION unknown by 12 YES NO 2 NAME OF Middle 4. DATE Year Manth Day filled DECEASED DEATH (Type or print) 19 IF UNDER 1 YEAR IF UNDER 24 HRS 9. AGE (In years 6. COLOR OR RACE 7. MARRIED NEVER MARRIED last birthday) Days Months Hours camplete DIVORCED | WIDOWED papers. 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) ond MISUN Mar 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME physician 17. INFORMANT 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause per lime for (g), (b), and (c).] atten ONSET AND DEATH PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) DUE TO by Canditians, if any, which mi. gned gave rise to immediate **DUE TO** cause (a), stating the underlying cause last. burial-transit peen PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES | NO S attending 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING GALUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) the OS 20e. PLACE OF INJURY (Hame, farm, 20f. (City or town) 20c. TIME OF INJURY (State) Manth. 20d. INJURY OCCURRED Day, Year (County) use to bu factory, street, affice bldg., etc.) Haur a. m. While Nat while this at work at wark 21 (certify that (1) (this hospital) attended the deceased from 4-14 19 57, and that deoth accurred at/AM, from the causes and on the dote stated above. saw the deceased olive on 22a. SIGNATURE ATTENDING PHYS. DIRECT STAFF PHYS. M.D. DIRECTOR 22 PHYSICIAN'S NAME (Type) 22d. ADDRESS should may be reto page 3 st the State NAME OF CEMETERY OR CREMATORY 23b. DATE THEREOF, or county! BURIAL, CREMATION, REMOVAL (Specify) 25-25-00 10 2Sb. REGISTRAR'S SIGNATURE ADDRESS 24\_FUNERAL DIRECTOR'S SIGNATURE Orthur S. Krais VR A15 (4) DATE

1SM 9/59



# FOR STATE TO DEPUTY CEDITY. EXAMINER: This certificate should be executed within 24 hours after coarth. If any delay is necessary, please execute the certificate, writing the word "pending" in pendil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

### MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 6663 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 06647

1. PLACE OF D	EATH			2. USUAL RESIDEN	CE (Whare decessed	lived, If I	nstitution: Residen	ce before	dmission)
a. COUNTY				a. STATE		b. COUN		-	
	roll		MARYLAND	Marylan			Carrol		
write RURA	b. CITY OR TOWN (if outside corporete limits, write RURAL end give neerest town)  Rural Westminster				If outside corporete li		RURAL end give	neerest tov	vn)
					Westminst	er			
d. NAME OF H	IOSPITAL OR INSTITUTION	(if not in hosp	itel, give street eddress)	d. STREET ADDRESS					ESIDENCE A FARM?
R.F.I				R.F.D.#				YES T	
3. NAME OF DECEASED	First		Middle	Last	4. DATE	Month	Dey	Yea	r
(Type or print)	Mary	,	Ellen	Myers	DEATH	June			61
5. SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	B. DATE OF BIRTH		(In years	Months Deys	Hours	Min.
Female	White	WIDOWED	DIVORCED	June 1, 1910		угз.	Months Deys	nours	Min.
	UPATION (Give kind of wor of working life, even if retire		NO OF BUSINESS OR INDUST	RY 11. BIRTHPLACE (State	or foreign country)		12. CITIZEN C	OF WHAT	COUNTRY?
Housewi	lfe	OWI	n home	Carroll Co	.Maryland		U.S.A		
13. FATHER'S NA	ME			14. MOTHER'S MAIDEN	NAME	200			
Luthe	er Hahn			Mary Cl	ingan				
	ED EVER IN U.S. ARMED FO		OCIAL SECURITY NO. 17.	INFORMANT		Address			
No.	(II yes give well of deles of	POLYTCO)	None Mr	. Ivan Myers	R#5 We	stmin	ster. Ma	malan	A
210	OF DEATH [Enter only on	cause per lin	ne for (e), (b), end (c).]	0	1	<u>o viii-tii</u>	IN'	TERVAL BE	TWEEN
PART I.	DEATH WAS CAUSED BY	SIL	Las Tim	- la h	aug u	0 -	01	SET AND	DEATH
001	IMMEDIATE CAUSE (e)		10000	- 1		1			
11/5	DUE TO								
	Conditions, if any, which (b)								
gave rise to immediate cause  (a), stating the underlying  DUE TO									
cause last.	le didentying								
	OTHER SIGNIFICANT COND	TIONS CONT	RIBUTING TO DEATH BUT NO	OT RELATED TO THE TERMI	NAL DISEASE COND	ITION GIV	EN IN PART 1(e)	19. WAS /	
OH I		LINE X						YES T	NO NO
200 EVIERNI	AL CAUSE WAS	ON DESCRI	SE HOW INJURY OCCURED.	Enter nature of Injury In Pa	rt I or Part II of item 1	B )		11:3	HO DE
PART II. O	or CONTRIBUTING	11.	in les	Lines neither of injury in te	in to treat if of hem t	<i>v.</i> ,			
30c. TIME OF	FINJURY Month, Day, Ye			ACE OF INJURY (Home, fare	m. 20f. (City or toy	wn)	(County)		(State)
Hour		/ While	Not While fac	tory, street, office bldg., ato	Wishen	wite	Corre	e '	ma-
			ins described above, he	eld an Autopsy	Inspection .	Inquir	y and	in my c	pinion
death resul	Ited from: Natural c	auses ,	Accident . Suid	ide N. Homicide	Undeter	mined m	anner		
1 1 1 1 1 1 1 1	1	1 50		CHIEF MEDICAL	EXAMINER				
ACTUAL	Julion J	1.01	wood	ASSISTANT MED	DICAL EXAMINER		I	DATE SIC	NED
SIGNATUR							1 ~		
EXAMINER NAME (Type		1	MARSH		city, town, or county	)	6-1	- 4	1
22e. BURIAL, CRE/ REMOVAL (S	MATION, 22b. DATE THER	EOF :	22c. NAME OF CEMETERY O		22d. LOCATION		or country)	(Ste	ie)
Burial	6/10/61	1	Lutheran Cemet	tery	Uniontow	n. Ma	ryland		
23. FUNERAL DIE	ECTOR /2/ 16	0.1	ADDRESS	24e. RE	C'D BY REGISTRAR	24b. REGI	ISTRAR'S SIGNAT	URE	
C.O.F115	ss & Son. T	anevto	wn, Maryland	DATE	IN 9 '61	Cia	elling & Kra	LA.A.	
0 10 11 (0)	2 2011, 1		4		717 0		21. 7000		

TO THE TOTAL TOTAL n T ATTACA CANADA AND COMPANIES OF THE PROPERTY OF THE PARTY and a reason of the distribution of the females and the second of the se

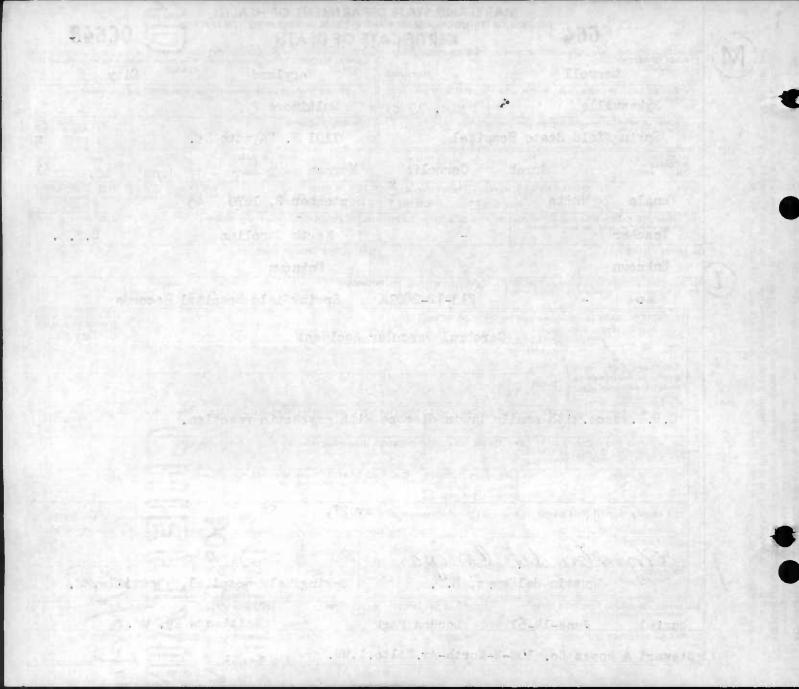
06648

(Stote)

X	CER	TIFICATE OF DEATH	7/67	16648
7	1. PLACE OF DEATH o. COUNTY Carroll	MARYLAND 2. USUAL RESIDENCE (Whe	ore deceased lived. If institution: Resident b. COUNTY Ci	nce before admission)
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give neprest town)  3 yrs.	stay in 16 c. city or town (if ou 15 days Baltimore	otside corporate limits, write RURAL and a	give nearest town)
5	d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION Springfield State Hospital	d. STREET ADDRESS	Sayette St.	e. IS RESIDENCE ON A FARM? YES NO
	3. NAME OF First NOTICE (Type or print) Sarah Corne	Aiddle Lost	4. DATE Month OF DEATH June	Doy Year 12, 1961
	S. SEX Female    6. COLOR OR RACE   7. MARRIED   NEVER N	AARRIED B. DATE OF BIRTH ORCED September 2,	1 4 4 4 4 4	Doys Hours Min.
3	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	ESS OR INDUSTRY 11. BIRTHPLACE (State o		U.S.A.
7	13. FATHER'S NAME Unknown	14. MOTHER'S MAIDEN NA Unknown		
7	IS, WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURIT (Yes, no, or unknown) (If yes, give war or dates of service) 213–12		Address eld Hospital Record	ls
	Conditions, if ony, which gove rise to immediate cause (a), stating the <u>under-</u>	od (c).] Vascular Accident		INTERVAL BETWEEN ONSET AND DEATH
0	C.B.S. assoc. with senile brain of	O DEATH BUT NOT RELATED TO THE TERMIN ISEASE WITH PSYCHOTI	NAL DISEASE CONDITION GIVEN IN PAR C reaction.	RT 1(o) 19. WAS AUTOPSY PERFORMED? YES NO
	GE OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	URY OCCURRED. (Enter noture of injury in Po	art I or Part II of item 18.)	
	20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRE Hour a. m. While Nat while of work of wark	foctory, street, office bldg., etc.)		County) (Stote
	21. I certify that (I) (this hospital) attended the decer			
1	saw the deceased alive on 19, 7  220. SIGNATURE  Clarific Company  22C. PHYSICAN'S  NAME Type  Agustin del Campo M	ATTENDING MEI	D. STAFF. PHYS. T	22b. DATE SIGNE
	23o. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF	F CEMETERY OR CREMATORY	d Hospital, Sykesvi	(Stote)
0	burial June-14-61 Loud  24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS	on Park	Baltimore 29, Md.	GNATURE

Stewart & Mowen Co. 108-W-North-Av. Balto.1, Md.

may be rek TO FUNERAL DIRI page 3 shauld b VR A1S (4) 1SM 9/S9



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

	_	
		PLACE OF DEATH  2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  o. STATE  b. COUNTY  b. COUNTY  D. COUNT
图)	-	CAKBOLL MAKILAND MAKILAND CAKBOLL
		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  C. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
,	_	UNION BRIDGE YEARS X UNION BRIDGE MD
X		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  e. IS RESIDENCE ON A FARM?
1		ELGER ST VES NOX
		NAME OF DECEASED (Type or print) MIRIAN ELIZABETH OGLE DEATH JUNE 1961
	S.	lost birthdoy) Months Doys Hours Min.
(	100	USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country)  12. CITIZEN OF WHAT COUNTRY?
(I)	1.00	during most of working life, even if retired)
0	12	HOUSE WIFE OWN HOME MARYLAND USIT
	13.	- 11.1 Analdra-n
	16	70111 //0-2/11///
		s. no, or unknown)     If yes, give wor or dates of service)
		NO NONE CLARENCE STEINBURG NEW WINDSOR M
		18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]  INTERVAL BETWEEN ONSET AND DEATH
		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (0) Care brovascular accident, probably hemmy loge 121
		331X DUE TO
		Conditions, if ony, which (b)
		gove rise to immediate Couse (a), stating the under-
	13	lying couse lost. (c)
	ON N	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED?
	S	Coneplesed arterio sclerosia. Coronar artem diseaso. YES NO D
0	CERTIFICATIO	20a. ACCIDENT WAS UNDERLYING   20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)  OR CONTRIBUTING   CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
	MEDICAL	20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (Stote)
	WED	Hour o. m.  While Not while foctory, street, office bldg., etc.)
		21. I certify that (1) (this hospital) attended the deceased from Nov 25, 1959, to June 14, 1961 that (1) (we) last
		saw the deceased alive and tended in the death accurred at S. P.M., from the causes and an the date stated above.
		226. SIGNATURE 22b. DATE
		M.D. PHYS. DIRECTOR PHYS.   6/14/61 SIGNED
-		22c/PHYSICIAN'S 22d. ADDRESS
		SLAME (Type) J H CARICOFE UNION BRIDGE MD
	230	BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town, or county) (Stote)
	-	BURIAL 6/17/61 MT VIEW UNION BRIDGE MD
0	24.	FUNERAL DIRECTOR'S SIGNATURE 250. REC'D BY REGISTRAR 250. REGISTRAR'S SIGNATURE
M	1	DD Hartsler & Sons Union Bridge Md DATE JUN 1 9'61

THE STATE OF THE PARTY OF THE P JOHN CRAPITER TOWN THE PARTY OF The thirty of the transfer of the state of t the control of the co 

# FOR STATE

HEALTH DEP TO DEPUT. (ED. L. EXAMINER: This certificate should be executed within 24 hours aft. Ath. If any delay is necessary, please execute the caraficate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-fransit permit. File pages 1 and 2 with the State Board of Hayth, or its designated agent, prior to burial, cremation, or removal, and in any over within 72 hours after death.

VS. A15ME 5M 7/59

### MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, O O O MEDICAL EXAMINER'S 301 W. PRESTON STREET, BALTIMORE 1, 06650 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

19 1	1. PLACE OF DEATH					2. USUAL RESIDENCE (Where decaesed livad, If institution: Residence before edmission)					
6	e. COUNTY		a. STATE b. COUNTY								
1	b. CITY OR TOWN (if outside corporate limits, write RURAL end give nearest town)					Maryland  c. CITY OR TOWN (If outside corporate limits, write RURAL end give nearest town)					
VI.				25 /7	ma	T = 0	++	0.1			
1	Sykesville 35 yrs./1 mo.  d. NAME OF HOSPITAL OR INSTITUTION (if not In hospital, give street eddress)					d. STREET ADDRESS	timore	City,	Maryla	nd l e. IS F	ESIDENCE
113		eld State I				?		3V	01-4	ON	A FARM?
3	NAME OF DECEASED	First	*	Middla		Last	4. DATE	Month	1	Dey Yes	r
	(Type or print)	Winter		infield		PARSONS	DEATH	6	- 2		61
1	5. SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	□   B.	DATE OF BIRTH	9	AGE (In years last birthday)			R 24 HRS.
-	male	white	WIDOWED	DIVORCED	X	?		63 yrs.	Months De	ys Hours	Min.
		ON (Give kind of work rking life, evan if retired		ND OF BUSINESS OR IN	NDUSTRY	11. BIRTHPLACE (Stete	e or foreign cou	intry)	12. CITIZE	N OF WHAT	
_	Laborer					Maryland				U.S.A	•
	3. FATHER'S NAME					14. MOTHER'S MAIDEN	NAME				
	Alfred F	arsons				Armetta	Wills				
		ER IN U.S. ARMED FOR		SOCIAL SECURITY NO.	17. IN	Winter W.	Damana	Address	19 Korri	n Pond	20
	no	Tycogree wor or dutes or se	177007		Mr.	spital Reco	rarsons rds	Syke	sville.	Marv	and
=	18. CAUSE OF D	EATH [Enter only one	cause per li	ne for (e), (b), and (c).		PhinaT 10000	2.45	Dyno	014440	INTERVAL BE	TWEEN
	PART I. DEAT	H WAS CAUSED BY:	0.2	770	no	plus in	,			ONSET AND DEATH	
	1 11000	IMMEDIATE CAUSE (e)_	20		UC	Cuchon				7	
4	1 20	DUE TO									
	Conditions, if eny, which (b)										
	(a), steting the underlying DUE TO										
	cause lest.	(c)_						100			
1	PART II. OTHER	SIGNIFICANT CONDIT	IONS CON	TRIBUTING TO DEATH	BUT NOT	RELATED TO THE TERM	INAL DISEASE	CONDITION GIV	EN IN PART 1		AUTOPSY DRMED?
	Schizophrenic Reaction, Paranoid type in a mental defective.								NO X		
	20a. EXTERNAL C	Schizophrenic Reaction, Faranoid type in a mental delective.  20s. EXTERNAL CAUSE WAS   20b. DESCRIBE HOW INJURY OCCURED. (Entar neture of Injury In Pert I or Part II of item 18.)									
	Schizor  Schizor  200. EXTERNAL CO PRIMARY [] or CO CAUSE OF DEATH.	NTRIBUTING									
3	20c. TIME OF INJU	RY Month, Day, Yas	r 2Dd. I			E OF INJURY (Home, fer		or town)	(County	)	(Stata)
1	Hour a.m.	19	et work	et work							
	21. I certify th	at I took charge o	f the rema	ains described abo	ve, held	an Autopsy ,	Inspection	M. Inquir	y V. 8	and in my	pinion
	death resulted	rom: Natural ca	uses .	Accident .	Suicio	le , Homicide	Un'	determined m	nanner 🗍		7.91
)		A	40			CHIEF MEDICAL	EXAMINER [				
1	ACTUAL		01	and I		ACCICTANT ME	_	ED []		DATE SI	SNED
	SIGNATURE	ALLEN	770	^ -	_	_ M.D.				1 /	1
	EXAMINER'S	1 10 = 0	1	Mana	11	DEPUTY MEDICA		*		6/50	1111
=	NAME (Type)	TINE S	) E	22c. NAME OF CEME	TERV OR	Address (Street,		county) ION (City, town	an equator)	(Ste	1141
	REMOVAL (Specify		or	ZZC. NAME OF CEME	IEKT OK	CREMATORT	220. LOCA	IION (City, lown	, or country)	(216	10)
1.	Burial	6-27-61		Druid Ridg	e Ce	metery	Pike	sville.	Maryla	nd	
1	23. FUNERAL DIRECTO	R	1	à LIESS : 12	RILL	a Clie 248. RE	C'D BY REGISTI	RAR   24b. REG	ISTRAR'S SIGN	LATURE	
	Home Vilus	lener & Le	ain	Bull	17	THE DATIUL	N 2 6 '61	10000	- S. Th	MA	
-	1	/			1-1-1						

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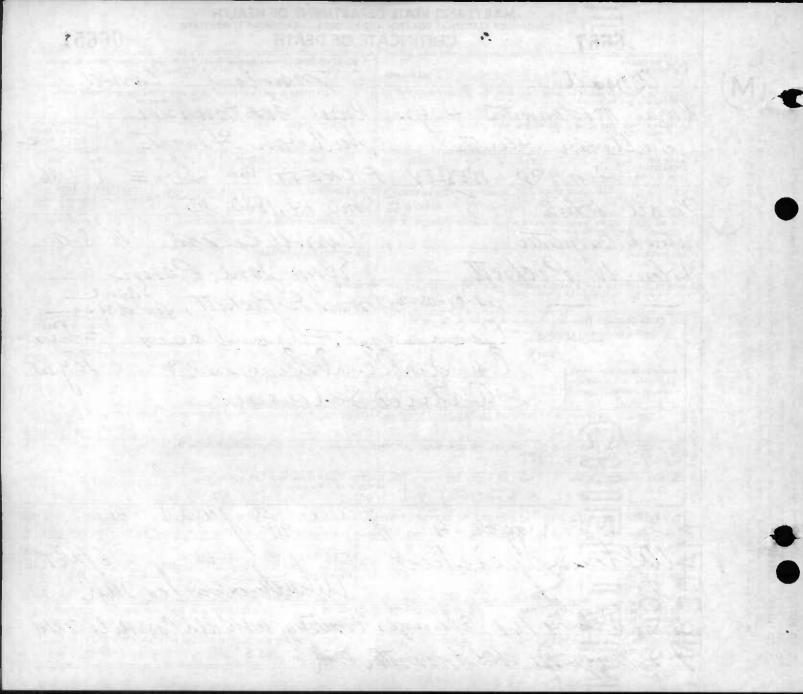
director,

Page 4

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

	6667 CERTIF	06651	
	D. CITY OR TOWN (If outside corporate limits, write   c. LENGTH OF STAY)	Mamana	Carroll
,	d. NAME OF HOSPITAL (If not in haspitol, give street address) OR INSTITUTION	2. Russ Westman.	e. IS RESIDENCE ON A FARM? YES NO
	3. NAME OF DECEASED (Type or print) HOMARD WESLEY  5. SEX   6. COLOR OR RACE   7. MARRIED PRIVER MARRIED	PICKETT DEATH SU	Manth Day Year  1 N = 196/  ara   IF UNDER 1 YEAR   IF UNDER 24 HRS.
	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 100. USUAL OCCUPATION (Give kind of wark dane during most of working life, even if retired) 100. USUAL OCCUPATION (Give kind of wark dane during most of working life, even if retired)	□ Jane 14,1880 go	
	13. FATHER'S NAME  13. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO.	14. MOTHER'S MAIDEN NAME  17. INFORMANT	M-S-Q-
9	(Yes, no, or unknown) (If yes, give war or dates of service)  18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).]  PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)	Howard & Pickett,	AND INTERVAL BETWEEN ONSET AND DEATH
	Canditions, if any, which gave rise to immediate couse (o), storting the under-lying couse last.  DUE TO  Cardio  Card	Revaldesense:	7- 10 yes
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEAD  20g. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	ATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION  CCURRED. (Enter nature of injury in Part I or Part II of item 18.)	PERFORMED? YES NO
		20e. PLACE OF INJURY (Hame, farm, factory, street, office bldg., etc.)	(County) (State)
	21. I certify that (I) (this haspital) attended the deceased saw the deceased glive an Way 26 19 61, and 22a. SIGNATURE	thou death accurred at Tel.M. from the causes	and on the date stated above.
	22c. PHYSICIAN'S NAME (Type)	M.D. ATTENDING MED. STAFF PHYS.   22d, ADDRESS WILLIAM STAFF	termel
	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEME SEMOVAL (Specify) 24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		SASSAU LO MA EGISTRAR'S SIGNATURE
1	K. V. minnih. West nim	ister Mid DATE JUN 5 '61	Chilhur S. Thomps



	DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  CERTIFICATE OF DEATH  06652
director director	1. PLACE OF DEATH o. COUNTY Carroll  2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland  Dorchester
the funeral should be	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn)  Henryton  c. LENGTH OF STAY IN 1b  Z78 days  c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Vienna
d by	d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION Henryton State Hospital  d. STREET ADDRESS  R.F.D. 1, Box 10  e. IS RESIDENCE ON A FARM? YES \( \subseteq \text{NO.} \subseteq \)
filled in ges 1 an	3. NAME OF DECEASED (Type or print) Medford Cornelius Pinkett  4. DATE OF OF DEATH June 10 1961
pletely pletely after de	5. SEX    6. COLOR OR RACE   7. MARRIED   NEVER MARRIED     8. DATE OF BIRTH     9. AGE (In years lost birthday)     Months   Days   Hours   Min.
ond cam bon pape 72 haurs	10a. USUAL OCCUPATION (Give kind of work dane during most of working life, even if retired)  Laborer — Phillips  Packing Company  Vienna Maryland  U.S.A.  13. FATHER'S NAME
g physician remove cark within	Rufus Pinkett  Ethel Ball  15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT  Address
o g s	(Yes. no. or unknown) (If yes, give wer or date of service)  220-01-7130 Medford C. Pinkett - patient  1B. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]
law requires that the death ysician. been signed by the attendir transit permit. Then please an, or remaval, and in any	PART II. DEATH WAS CAUSED BY: Far advanced bilateral pulmonary tuberculosis,  Canditions, if ony, which gove rise to immediate cause (a), stoting the under-lying cause lost.  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19. WAS AUTOPSY PERFORMED?
IAN: The ending ph ficate has the burial the burial of crematiful	YES NO OCCUPANT WAS UNDERLYING CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
PHYSIC al ar att this certi r use as r to buric	20c. TIME OF INJURY Month, Day, Year Haur a. m.  p. m.  19  20d. INJURY OCCURRED While Not while of work of wo
TENDING pspir TON After detached fo Health prior	21. I certify that (I) (this haspital) attended the deceased from Sept. 6, 1960 to June 10, 1961, that (I) (we) last saw the deceased alive an June 10, 1961, and that death accurred a 40, from the causes and an the date stated abave 220. SIGNATURE Edgars M. Massilan Med. Attending Med. STAFF
report of Board of Search	ATTENDING MED. STAFF DIRECTOR STAFF PHYS. DIRECTOR
may be may be page 3 the State	23a. BURIAL, CREMATION, 23b. DATE THEREOF  REMQVAL (Specify)  Tune 14, 1961  23c. NAME OF CEMETERY OR CREMATORY  Vienna, Grayand  (State)
VR A15 (4) 15M 9/59	2 TUNERAL DIRECTOR'S SIGNATURE ADDRESS ADDRESS 250. REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE DATE 1 3 61 ONLY S. KINS

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	1, 20 000		Nicelanda yeara

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# MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

06653

	1, PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where decease		e before admission)					
1	Carroll	MARYLAND	o. STATE Maryland b. COUNTY							
/	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Rural - Sykesville	3yr.llmo.llda	c. CITY OR TOWN (If outside corp.  Baltimore C.		ye nearest town)					
	d. NAME OF HOSPITAL (If not in hospital, give street OR INSTITUTION	oddress)	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?					
5	Springfield State Hosp	oital	3724 Hudson St	reet	YES NO TO					
	3. NAME OF First DECEASED (Type or print) Vera	VERENICZ	PORRECA 4. DATE OF DEATH	Month June	12 Year 19 61					
	S. SEX 6. COLOR OR RACE 7. MAR	NEVER MARRIED	B. DATE OF BIRTH		YEAR IF UNDER 24 HRS.					
	Female White WIDOW	VED DIVORCED	1-6-20	lost birthdoy) Months yrs.	Doys Hours Min.					
	10a. USUAL OCCUPATION (Give kind of work done 10b. during most of working life, even if retired)	. KIND OF BUSINESS OR INDUS	TRY 11. BIRTHPLACE (State or foreign of		EN OF WHAT COUNTRY?					
	Housewife	At Home.	Maryland , Ba	altimore U.	S.A.					
	13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
1	Jacob Warenicz		Anna Dounouk	The state of the s						
1	15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. (Yes, no, or unknown)   (If yes, give war or dates of service)		FORMANT	Address						
	No		Hospital Records							
	18. CAUSE OF DEATH [Enter only one couse per l	ine for (a), (b), and (c).]			INTERVAL BETWEEN					
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)	Bronchopneumonia	a		36 hours					
	Conditions, if only, which gove rise to immediate couse (a), stating the under-lying couse lost.  CBS associated with inti	CONTRIBUTING TO DEATH BUT	not related to the terminal diseation, other than s	se condition given in fact ypnilis, epide	19. WAS AUTOPSY PERFORMED? YES NO IN					
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS COME TO THE CONTRIBUTION OF THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS CONTRIBUTION OF									
	Occ. TIME OF INJURY Month, Doy, Year 20d. Hour o. m. While of wo	Not while foc	CE OF INJURY (Home, form, tory, street, office bldg., etc.)		ounty) (Stote)					
	21. I certify that (A) (this haspital) attended saw the deceased alive an June	21. I certify that (A) (this haspital) attended the deceased from January 11, 1955, to June 12, 1961, that (A) (this haspital) attended the deceased from January 11, 1955, to June 12, 1961, that (A) (this haspital) attended the deceased from January 11, 1955, to June 12, 1961, that (A) (this haspital) attended the deceased from January 11, 1955, to June 12, 1961, that (A) (this haspital) attended the deceased from January 11, 1955, to June 12, 1961, that (A) (this haspital) attended the deceased from January 11, 1955, to June 12, 1961, that (A) (this haspital) attended the deceased from January 11, 1955, to June 12, 1961, that (A) (this haspital) attended the deceased from January 11, 1955, to June 12, 1961, that (A) (this haspital) attended the deceased from January 11, 1955, to June 12, 1961, that (A) (this haspital) attended the deceased from January 11, 1955, to June 12, 1961, that (A) (this haspital) attended the deceased from January 11, 1965, to June 12, 1961, that (A) (this haspital) attended the deceased from January 11, 1965, to June 12, 1961, that (A) (this haspital) attended the deceased from January 11, 1965, to June 12, 1961, that (A) (this haspital) attended the deceased from January 11, 1965, to June 12, 1961, that (A) (this haspital) attended the deceased from January 11, 1965, to June 12, 1961, that (A) (this haspital) attended the deceased from January 11, 1965, to June 12, 1961, that (A) (this haspital) attended the deceased from January 11, 1965, to June 12, 1961, that (A) (this haspital) attended the deceased from January 11, 1965, to June 12, 1961, that (A) (this haspital) attended the deceased from January 11, 1965, to June 12, 1961, that (A) (this haspital) attended the deceased from January 11, 1965, to June 12, 1961, that (A) (this haspital) attended the deceased from January 11, 1965, to June 12, 1961, that (A) (this haspital) attended the deceased from January 11, 1961, that (A) (this haspital) attended the deceased from January 11, 1961, that (A) (this haspital) attended the deceas								
	220. SIGNATURE A SCOU	um,	ATTENDING MED. PHYS. DIRECTOR  22d. ADDRESS	STAFF PHYS.	22b. DATE SIGNED 6-12-61					
	22c. PHYSICIAN'S NAME (Type) Ilse Kamm, 1	eld State Hosp ille, Maryland	ital							
	230. BURIAL, CREMATION, 23b. DATE THEREOF BURIAL 6-15-61	23c. NAME OF CEMETERY OF HOLY Trini	1 0 1	TION (City, town, or county) Licridge	(Stote) Md •					
	24 FUNERAL DIRECTORS STENATURE 90	l SADDRESS Balto 24 Md	St. 250. REC'D BY REGIS							

Page 4

nin 24 haurs after de

may be retain by it spital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physician and campletely filled in by the funeral director, page 3 should be detached far use as the burial-transit permit. Then please remove carban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 haurs after death. 4G PHYSICIAN: The law requires that the death certificate be execute

TO HOSPITAL VR A1S (4) 1SM 9/59

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STATE DEPARTMENT OF HEALTH **BALTIMORE 1, MARYLAND** RECORDS, FOR STA 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where decessed lived, If institution: Residence before edmission) SUNTY files. Health, b. COUNTY to the funeral director. Page e. STATE MARYLAND CITY OR TOWN (if oulside corporete limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) is neces write RULAL end give neerest lown) retained for your d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) Boar If any delay State death. NAME OF First Middle DATE Month 4. DECEASED OF the LMER DEATH (Type or print) 2 2 with 8. DATE OF BIRTH 5. SEX COLOR OR RACE AGE (In yeers | IF UNDER 1 YEAR 7. MARRIED NEVER MARRIED Page 5 m. land 2 w. ast birthdey) Months WIDOWED DIVORCED certificate should be executed within 24 hours after USUAL OCCUPATION (Give kind of work 10b, KIND OF BUSINESS OR INDUSTRY | 11, BIRTHPLACE (State or foreign country) Page done during most of working life, even if relired)

SAUYER 13. FATHER'S NAME "pending" in pencil in Item 18. Give Pages 1, pages Within Office along with form PM3. burial-transit permit. File page MOTHER'S MAIDEN NAME WAS DECEASED EVER IN U.S. ARMED FORCES 17. INFORMANT 16. SOCIAL SECURITY NO. Address (Yes, no, or unkown) | (Ifyes give wer or detes of service) any 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), end (c). E PART I. DEATH WAS CAUSED BY: and IMMEDIATE CAUSE (e) DUE TO removal, Conditions, if eny, (b) geve rise to immediate cause Examiner's FOI DUE TO (e), steling the underlying as 9 cause lest. (c) pe nsed ion, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY CERTIFICATION cremati the word Medical pluods 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.) PRIMARY OF CONTRIBUTING EXAMINER: CAUSE OF DEATH. 20e PLACE OF INJURY (Home, farm, 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20f. (City or town) tactory, street, office odg., etc.) Not While et work et work 21. I certify that I took charge of the remains described above, held an Autopsy Inspection 7 Inquiry death resulted Suicide X Homicide Undetermined manner from: Natural causes Accident please execute the cer CHIEF MEDICAL EXAMINER ACTUAL ASSISTANT MEDICAL EXAMINER SIGNATURE DEPUTY MEDICAL EXAMINER DEPUT EXAMINER'S NAME (Type Address (Street, city, town, or county)

**ADDRESS** 

IS RESIDENCE

ON A FARM? YES NO

Yeer

19

Hours

INTERVAL BETWEEN

ONSET AND DEATH

PERFORMED?

NO

(Stete)

and in my opinion

DATE SIGNED

(Slele)

YES

(County)

24b. REGISTRAR'S SIGNATURE

22d. LOCATION (City, town, or country)

24e. REC'D BY REGISTRAR I

12. CITIZEN OF WHAT COUNTRY?

IF UNDER 24 HRS.

Min.

Dey

10

Days

VS. A15ME 5M 7/59

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EREMATION

REMOVAL (Specify)

FUNERAL DIRECTOR

22b. DATE THEREOF

The State of the S 12 - 12 - 1 - 21 W ASSESSED ASS 224.31 The second secon THE PROPERTY OF THE PARTY OF TH The same of the sa The same of the way and the water of a same The state of the same that the state of the the series of the series of the series of the series of Later Charles CAMPIANES TIMESH Control of the second of the s

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MARYLAND STATE DEPARTMENT OF HEALTH 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND Division of STATISTICAL RESEARCH MEDICAL EXAMINER'S CERTIFICATE OF DEATH PLACE OF BEATH 2. USUAL RESIDENCE (Where decesed lived, If institution: Residence before edmission) a. COUNTY eth. If any delay is new sary, 3 to the funeral director. Page for your files. MARYLAND b. CITY OR TOWN (if outside corporete limits, c. LENGTH OF STAY IN 16 ortside corporete limits, o write RURAL and give nearesHown) Board .s d. NAME OF OR INSTITUTION (if not in hospitel, give street address) e. IS RESIDENCE ON A FARM? retained State YES NO 3. NAME OF DATE DECEASED OF the (Type or print) DEATH 19 DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. MARRIED NEVER MARRIED may iff 2, and 3 ge 5 mar 1 and 2 y last birthdey) Months WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if refired) 10b. KIND OF BUSINESS OR INDUST 12. CITIZEN OF WHAT COUNTRY? certificate should be executed within 24 hours aft Page in Dencil In Item 18. Give Pages 1, pages 1 within form PM3. FATHER'S NAME SOCIAL SECURITY NO. permit. (Yes, no, or unkown) | (If yes give we ror detes of service) Office along with 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c).] INTERVAL BETWEEN ONSET AND DEATH burial-transit PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e) DUE TO removal. Conditions, if eny, which geve rise to immediate cause "pending" 15 DUE TO (a), stetling the underlying 98 Examiner cause lest. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY CERTIFICATION PERFORMED? cremati 9 writing the word Medical should 200. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED, (Enter neture of Injury in Pert I or Pert II of Item 18.) PRIMARY | or CONTRIBUTING | CAUSE OF DEATH. age 3 sto buria Chief 20c. TIME OF INJURY Month, Dey, Yeer 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, ! 20f. (City or town) (County) (State) factory, street, office bldg., etc.) While Not While et work - at work please execute the capificate, v 4 should be forwarded to the O FUNERAL DIRECTOR: P prior 21. I certify that I took charge of the remains described above, held an Autopsy Inspection | Inquiry and in my opinion death resulted from: Accident Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER designated ACTUAL DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATUL DEPUTY MEDICAL EXAMINER MINE DEPUT Address (Street, city, town, of county) 22d. LOCATION (City, town, or country) VS. A15ME arihun S. Kraus 5M 7/59

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# MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

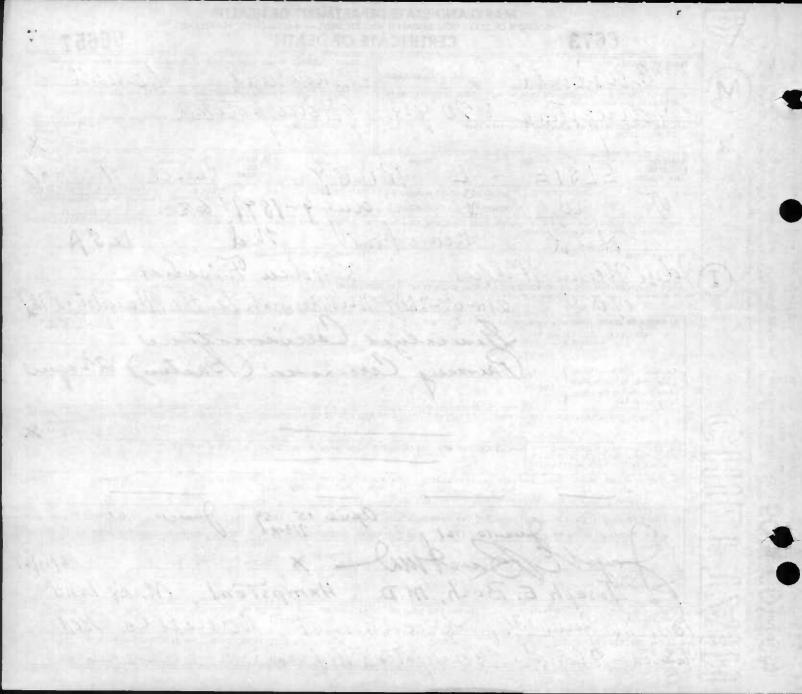
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1.	PLACE OF DEATH  a. COUNTY  MARYLAND  2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  b. COUNTY  b. COUNTY  LIVELLE  B. COUNTY
1	b. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) RURAL and give nearest town)
	d. NAME OF HOSPITAL (If not in haspital, give street oddress)  d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES \( \sum \) NO \( \sum \)
3.	NAME OF DECEASED (Type or print) ELS/E - L Middle PUBY 4. DATE OF DEATH JULIE 1/ 196/
	SEX OFF   6. COLOR OR RACE   7. MARRIED   NEVER MARRIED   B. DATE OF JIRTH   9. AGE (In years lost methody)   Months Doys Hours Min.
	On USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BINTHPLACE (Stote or foreign country)  12. CITIZEN OF WHAT COUNTRY?
13	HALLE HELLE HELLES TO SOCIAL SECURITY NO. 17. INFORMANT Address Address Address
P(Y	(es, no, or unknown) The 216-07-2607 Mis Bleuch Leather, Harripstead The
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  PERCENTIAN DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  PERCENTIAN DEATH  ONSET AND DEATH
	Sondition if any which
	gove rise to immediate cause (o), stating the under-lying couse last.  (b) White (b) DUE TO
CERTIFICATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED?  YES \( \subseteq \text{NO} \)
MEDICAL	20c. TIME OF INJURY Manth, Doy, Year 20d. INJURY OCCURRED Haur a. m. While Nat while of work of work of work of work of work.
	21. I certify that (I) (this haspital) attended the deceased fram april 15, 1959, to June 11, 1961, that (I) (we) last saw the deceased alive on June 10, 1961, and that death accurred 21, 399 M, fram the causes and an the date stated above.
	220. SIGNATURE  226. DATE SIGNED  ATTENDING  ATTENDING  ATTENDING  DIRECTOR  STAFF  PHYS.  Company  Co
	Pare Toseph E. Bush, M.D. Hampstend Mary land
23	So BURAL, CREMATION, 236. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town, or county) (Stote)
24	ADDRESS 250. REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE

Page 4

thin 24 haurs after d DING PHYSICIAN: The law requires that the death certificate be execut

TO FUNERAL DIRECTON After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 should be detached far use as the burial-transit permit. Then please remove carban papers. Pages 1 and 2 shauld be filed with the State Board of Health priar to burial, cremation, or remayal, and in any event within 72 haurs after death. TO HOSPITAL VR A15 (4) 1SM 9/S9



VS A1S (4) 1SM 9/SB

# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 6674

**CERTIFICATE OF DEATH** 

Reg. Dist. No. 06658

1. PLACE OF DEATH o. COUNTY Carroll Cou	inty MARYLAND	2. USUAL RESIDENCE (WO O. STATE		CO	timore
b. CITY OR TOWN (If outside corporate RURAL and give nearest town)  Sykesville	limits, write c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (IF	outside corporate limit	ts, write RURAL and	give nearest town)
d. NAME OF HOSPITAL (If not in hospite OR INSTITUTION Golden A	ol, give street oddress)  Age Nursing Home	d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES NO
	First Middle ENCE ARRETTA SEITZ	Last Z	4. DATE OF DEATH	June 2	9, 1961 19
5. SEX 6. COLOR OR RA Female White	CE 7. MARRIED NEVER MARRIED NUMBER MIDOWED DIVORCED	8. DATE OF BIRTH April 1, 187	7 9. AGE	(In years pirthdoy) yrs.	R 1 YEAR IF UNDER 24 HRS.  Days Hours Min.
10a. USUAL OCCUPATION (Give kind of wo during most of working life, even if ret Housewife	ork done 10b. KIND OF BUSINESS OR INDL ired)  Own Home	JSTRY 11. BIRTHPLACE (Stot		12.CI	TIZEN OF WHAT COUNTRY?
13. FATHER'S NAME  Joseph Keller		14. MOTHER'S MAIDEN	NAME arbara Smit	th	
1S. WAS DECEASED EVER IN U. S. ARMED (Yes, no, or unknown) (If yes, give wor or dated None	of service)	INFORMANT Family Record	8	Address	
Conditions, if ony, which gove rise to immediate couse (a), stating the underlying couse lost.  PART II. OTHER SIGNIFICANT C	EYE (o)  (b)  TO  (c)  CONDITIONS CONTRIBUTING TO DEATH BU	1	/		INTERVAL BETWEEN ONSET AND DEATH  ONSET AND DEATH
	ER)	1	1		
20c. TIME OF INJURY Month, Doy, Hour o. m. p. m.	Year 20d. INJURY OCCURRED While Not while of work of work	LACE OF INJURY (Home, for octory, street, office bldg., e		)	(County) (Stote)
21. I certify that I attended alive on ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)	D 100 /	h accurred at	My from the ca	uses and an	ast saw the deceased the date stated abave. DATE SIGNED
220. BURIAL, CREMATION, REMOVAL (Specify)  Burial  July 2.1	22c. NAME OF CEMETERY C		22d. LOCATION (CI	ty, tawn, or county	(Stote)
23. FUNERAL DIRECTOR'S SIGNATURE	ns, Towson, Md.		C'D BY REGISTRAR	24b. REGISTRAR'S S	

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24g, REC'D BY REGISTRAR

DATE

JUN 2 0

24b. REGISTRAR'S SIGNATURE

Cinthun & House

director, iled with Filed funeral pe should the 24 70 filled completely pup pon ofter corl physician гетауе hours attending ease vithin d þ FUNERAL DIRECTO 3 should poge 10 VS A1S (4) 1SM 9/5B

a. COUNTY

3. NAME OF

S SEX

CAL

MEDI

alive an

ACTUAL

23 FUNERAL DIRECTOR'S SIGNATURE

**ADDRESS** 

DECEASED

Ceretical Thremboon 3 460-12 arteriorelinerie 1/20/58 9450 4/14/61 6/16/41 M. E. Robertson Hen wander int blicker The second secon 

VR A15 (4) 1SM 9/S9

MARYLAND STATE DEPARTMENT OF HEALTH

6676 CERTIFICATE OF DEATH

	00	78 C	ERTIFICATE	OF DEATH		06666	)
	1. PLACE OF DEATH a. COUNTY WILL		MARYLAND 2	USUAL RESIDENCE (Whe	b. COUNTY	n: Residence befare admi	ission)
	b. CITY OR TOWN (If autside car RURAL and give nearest town)	10	H OF STAY IN 1b	c. CITY OR TOWN (If au	tside carporate limits, write RU	RAL and give nearest tax	wn)
	d. NAME OF HOSPITAL (If not in OR INSTITUTION		1	d. STREET ADDRESS	male	ON	ESIDENCE A FARM?
	3. NAME OF	First	Middle	3 / Lost	4. DATE Month		Yeor
	DECEASED (Type ar print)	RA VIR	GINIA	SETTLE	OF DEATH JUN		196/
	Female Wh	OR RACE 7. MARRIED NEW	DIVORCED   8. I	Pel 5 18	9. AGE (In years lost birthday)	Manths Days Haurs	
	during most of working life, eve		USINESS OR INDUSTRY	11. 8IRTHPLACE (State o	r foreign country)	12. CITIZEN OF WHAT	COUNTRY?
-	13. FATHER'S NAME	1 11	1	4. MOTHER'S MAIDEN NA	AME / - D	,	
L	newton C.	Williams	CURITY NO. 17. INFO	mm	aline Do	nham	
	1S. WAS DECEASED EVER IN U. S. A (Yes, no, or unknown) (If yes, give wo	RRMED FORCES? 16. SOCIAL SEC	- P	Mut 7-8	Cettle Las	ne addre	112
		only one couse per line far (a), (	b), and (c),	/		INTERVAL E	BETWEEN ID DEATH
	PART I. DEATH WAS CA	DUE TO	trul ho	munha	38	Ju	dden
	Conditions, if any, which	(b)					
	couse (a), stating the <u>under-</u> lying cause last.	DUE TO					
	CATIC	CANT CONDITIONS CONTRIBUTI	ING TO DEATH BUT NO	OT RELATED TO THE TERMIN	ial disease condition give	PERF	S AUTOPSY FORMED?
	OR CONTRIBUTING CAUSE (IF EITHER, NOTIFY MEDICAL EX	ING DESCRIBE HOW OF DEATH (AMINER)	/ INJURY OCCURRED. (I	Enter nature af injury in Po	ort I ar Part II of item 18.)		
	20c. TIME OF INJURY Manth, Haur a.m. p. m.	Doy, Year 20d. INJURY OCC While Not wark at war	while factory	OF INJURY (Hame, farm, y, street, affice bldg., etc.)	EXCEPT T	HER DEA	D (Stote)
		hospital) attended the d		117700	TEND HER	SIHE, that (I)	
	22a. SIGNATURE	Chapker	M.D		D. STAFF PHYS.		26. DATE SIGNED
	22c. PHYSCIAN'S NAME (Type)	us Chepk	6	22d. ADDRESS	Lestminst	er, Mb.	
	23a. BURIAL, CREMASION, 23b. DA	TE THEREOF 23c. NAN	ME OF CEMETERY ORC	REMAJORY CIN	23d. LOCATION (City, town, or	(St.	ate) —
	24. FUNERAL DIRECTOR'S SIGNATUR	RE ADDR	RESS	20. 1		TRAR'S SIGNATURE	mi
	A comp	18/11/10	1 mmale	DATE IUN	13'61 ant	hun S. Thank	

DIE DESCRIPTION OF THE WARRENCE OF THE SAFER CONTRACTOR OF THE SAFER CONTRACTO Salar Chapter of the Salar Chapter LANGER CLERKS CONSTRUCTION The second section of the second second second

# TO FUNERAL DIRECTO. After this certificate has been signed by the attending physician ond completely filled in by the funeral directar, page 3 should be detached far use as the burial-transit permit. Then please remove carbon popers. Pages 1 and 2 shauld be filed with the State Board af Health prior to burial, cremation, or remaval, and in any event, within 72 hours after death. VOING PHYSICIAN: The low requires that the death certificate be executed

VR A1S (4) 1SM 9/S9

### MARYLAND STATE DEPARTMENT OF HEALTH

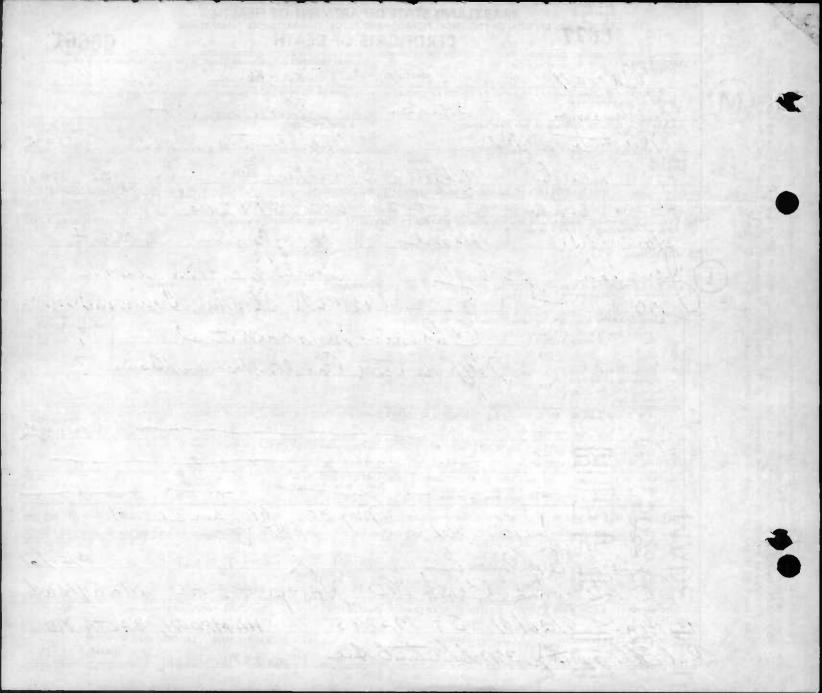
IVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

ISION OF	STATISTICAL	RESEARCH	AND	RECOR	DS —	BALTIM
	CEI	RTIFIC	ATE	OF	DE	ATH

6677

06661

		PLACE OF DEATH	A .	2. USUAL RESIDENCE			dence before adn	nission)
		COUNTY ( BYFO //	MARYLAND	o. STATE THE	extrust "	. COUNTY	erock.	noise .
1	Ь		LENGTH OF STAY IN 16	c. CITY OR TOWN	If autside corporate lim	its, write RURAL or	nd give nearest to	own)
1		BURAL and give nearest town)	3 Yeras	X X/s	osel en me	4		
	-	d. NAME OF HOSPITAL (If not in hospital, give street od	ldress)	d. STREET ADDRESS	1		e. 15 1	RESIDENCE
X		OR INSTITUTION CONTAINED POL	The Land	1.11.11.11	Timber ou	IPS.		A FARM?
	3. N	NAME OF First	Middle	/ Last	4. DATE	/ Month	Day	Year
	(	(Type or print)	Olivia	Selonahu	OF DEATH	June-	21	1961
	S. S	6. COLOR OR RACE 7. MARRIE	DEVER MARRIED	B. DATE OF BIRTH	9. AQE	(In years   IF UNI	DER 1 YEAR IF UN	
		firete White WIDOWED	DIVORCED	Och 12:1	07V 6	yrs.		
	10a.	. USUAL OCCUPATION (Give kind of work dane 10b. KI during phost of working life, even if retired)	ND OF BUSINESS OR INDU	STRY 11. BIRTHPLACE (SI	ate or foreign country)	12.0	CITIZEN OF WHA	T COUNTRY?
		2 faireinil	Home	MRKI	scared-	-	CLOA	
	13.	FATHER'S NAME		14. MOTHER'S MAIDE	NAME	)	,	
T	0	Germany Start	u	Josep	burne 1	morre	aura	/
٥	5.	WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SC	OCIAL SECURITY NO. 17.1	NFORMANT	011	Address		
		(if yes, give war or date of service)	June (	systel ?	Stonefice	1 Green	mount.	my
		1B. CAUSE OF DEATH [Enter only one couse per line	for (0), (b), ond (c).]	-			INTERVAL ONSET-AL	BETWEEN ND DEATH
		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)	Chrine	- huyor	auditi	0	1	
		443 V DUE TO -	1	- 1	10		3	
		Conditions, if ony, which ) (b)	4/hylerese	at Card	is-Voscus	lord bes	ca.	THE .
		gove rise to immediate couse (o), stating the under.	/					
		lying couse lost. (c)						
	NO.	PART II. OTHER SIGNIFICANT CONDITIONS CO	NTRIBUTING TO DEATH BU	NOT RELATED TO THE TE	RMINAL DISEASE CON	DITION GIVEN IN I	PART 1(o) 19. W/	AS AUTOPSY REORMED?
1	CAT	-					YES	
0	TIFE	20₀. ACCIDENT WAS UNDERLYING ☐ 20b. DESCR	RIBE HOW INJURY OCCURRE	D. (Enter noture of injury	in Port I or Port II of i	tem 1B.)		
	CERT	(IF EITHER, NOTIFY MEDICAL EXAMINER)						
	CAI			ACE OF INJURY (Home, I		n)	(County)	(Stote)
	MEDICA	Hour o. m. 19 While of work-	Nat while To	ctary, street, office bldg.,	77			
		21. I certify that (I) (this haspital) attende	d the deceased from	muy 30	196/ ta Xxx	421 19	6/ that (	\ (we) last
		saw the deceased alive an Hair ID	/ /	death accurred 61 5	11013			, ,
		220. SIGNATURE		dedili decorred di	J.M., Hight the c	doses and an	inc date state	22b.DATE
		Travella 12	1	M.D. PHYS.	MED. STA	FF 'S. 🗆	6,	SIGNED
1		22c PHYS CIAN'S NAME (Type)	7/1	22d. ADDRESS	u.			1 ,
		Joseph E. L	JUSH MIZ	> HAM	pst El	AD A	11841	and
	23a	BUMAL, CREMATION, 23b. DATE THEREOF	23c. NAME OF CEMETERY	OR CREMATORY	23d. LOCATION (C	City, town, or coun	(y) (S	Stote)
	13	10RIAL 6/26/6/	07 MA.	KYS	H4MP	DEN, B	ALTO	MD
1	33	FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	2So. R	EC'D BY REGISTRAR	25b. REGISTRAR'S		
6	Rec	ul Chenoweth or 3617	Chreland,	MUL DATE	MIN 2 6 '61	a. What i	2. Thates	



# FOR STATE

E

TO DEPUTY SELL IL EXAMINER: This certificate should be executed within 24 hours after the fany delay is necessary. The please execute the Adjificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Physalth, and its designated agent, prior to burial, cremation, or removel, and in any event within 72 pages after death.

VS. A15ME 5M 7/59

	MARY	LAND STATE D	EPARTMENT OF	HEALTH	
	TICAL RESEARC	CH AND RECORDS,	301 W. PRESTON	STREET, BALTIMORE	
6678	MEDICAL	<b>EXAMINER'S</b>	CERTIFICATE	OF DEATH	06662

1. PLACE OF DEATH		-1		2. USUAL RESIDE	NCE (Where de			idence befor	e edmission)
Car	רהי		MARYLAND	e. STATE	rvland	b. COUN	200	taamaa	V
b. CITY OR TOWN (if		its. 1 c.	LENGTH OF STAY IN 16	c. CITY OR TOWN		orate limits, write		tgomer	
write RURAL end g	ive neerest town)					0.7 675 0		-4	5-
Sykesvil			rs.5mos.2da	d. STREET ADDRESS	y Chase	15	- 1 -	) /	DECIDENCE
d. NAME OF HOSPITA	L OK INSTITUTION (	ir nor in nospital,	give street eddress)	d. SIKEEL ADDRESS	5			0	RESIDENCE NA FARM?
	eld Hospi	tal		4757	Chevy (	Chase Dr	ive	YES	NO
3. NAME OF DECEASED	First		Middle	Lasi	4. DATE	Month		Dey Y	'ear
(Type or print)	Pete		Anthony	Spatford	DEATH	June		27. 1	961
5. SEX	S. COLOR OR RACE	7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH	9.	last birthdey)			DER 24 HRS.
Male	White	WIDOWED	DIVORCED 🔀	February 27	7. 1914	47 yrs.	Months De	ys Hours	Min.
10a. USUAL OCCUPATIO	N (Give kind of work	10b. KIND C	OF BUSINESS OR INDUS			untry)	12. CITIZI	EN OF WHA	T COUNTRY?
done during most of worki		d)		Ohio			1	U.S.A.	
Lithogram  13. FATHER'S NAME	mer.		-	14. MOTHER'S MAIDE	NNAME			O.O.A.	
	Spadafor	e			11a She	bea			
15. WAS DECEASED EVER	es de		AL SECURITY NO.   17.	INFORMANT		Address		-	
Yes, no, or unkown) (Ify	sgivewerordatesofs	ervice)		Springfiel	ld Hospi	tal Rec	onde		
18. CAUSE OF DE		anus par line to	v (a) (b) and (a) 1	obi migrie.	rd mospi	toar nec	orus.	INTERVAL	DET)A/ECA!
	WAS CAUSED BY:							ONSET AN	D DEATH
IN IN	MEDIATE CAUSE (e)	Asphy	cia due to	occlusion of	traches	by foo	d.	Minut	es
121	DUE TO								
Conditions, if eny,	which 7 (b)							-100	
geve rise to immediate	DUE TO								
(e), stetling the und	erlying								
	J (c)	TIONS CONTRIB	UTING TO DEATH BUT N	OT RELATED TO THE TERM	AINAL DISEASE	CONDITION GIV	FN IN PART 1	(a) 19 WA	SAUTOPSY
PART II. OTHER S  C. B. S. 888  200. EXTERNAL CAU PRIMARY OF OF DEATH.	c.with Hu	intingtor	's Chorea	with psychot:	ic react	tion.		YES T	RFORMED?
20e. EXTERNAL CAU	SE WAS   2	Ob. DESCRIBE H	OW INJURY OCCURED.	(Enter neture of Injury In P	ert I or Pert II of	item 18.)		I-O	
	TRIBUTING [								
3 20c. TIME OF INJURY	Month, Dey, Ye		All the second	ACE OF INJURY (Home, fe		or town)	(County	у)	(State)
20c. TIME OF INJURY	6/27/ 196	While et work		ctory, street, office bldg., a ospital		esville	Carr	oll	Md.
21. I certify that	I took charge o	of the remains	described above, l	neld an Autopsy X,	Inspection	X, Inquir	у 🗶	and in my	opinion
death resulted from	ne: Natural ca	auses ,	Accident X. Sui	cide Homicide	e , Un	determined m	anner		
		1 -		CHIEF MEDICA	L EXAMINER	1 15 1	1000		
ACTUAL	tames	1 1	Voros	A ASSISTANT ME	EDICAL EXAMIN	ER T		DATE S	IGNED
SIGNATURE				M.D.	AL EXAMINER 3				
EXAMINER'S NAME (Type)	James T.	Marsh,	M.D.		, city, town, or			6/27/6	1
22e. BURIAL, CREMATION	226. DATE THERE	OF 22c.	NAME OF CEMETERY			ION (City, town	, or country)	(5	ilete)
REMOVAL (Specify) Burial	7/3/61	Δ	rlington 1	Nat. Cem.	Arl	Lingtor	. Vir	ginia	1
23. FUNERAL DIRECTOR	1/2/01	1 53	ADDRESS			RAR   24b. REG			
	Dannah	Day Day	thoods M				in S. Ki		
Kobert A	. Pumphr	ey, be	thesda, M	aryland DATEU	11 3 '61	1 000	24. 14.		

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DING PHYSICIAN: The law requires that the death certificate be executed

TO HOSPITAL

VR A1S (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06663

o. COUNTY Carrol1	MARYLAND	2. USUAL RESIDENCE (Who o. STATE Nary Lan	ere deceased lived. If institution: b. COUNTY	Residence before admission)  Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster	c. LENGTH OF STAY IN 16  14 Months	1	utside corporate limits, write RURA	L ond give nearest town)
d. NAME OF HOSPITAL (If not in hospitol, give street OR INSTITUTION  Westminster, Md. R.D.1 (		d. STREET ADDRESS Westminster,	Md. R.D.1 (Silv	er Run) e. IS RESIDENCE ON A FARM? YES NOT
3. NAME OF First DECEASED (Type or print)  James	Ammon St	onesifer	4. DATE Month OF DEATH June	Day Yeor 19 61
Mada total	RRIED NEVER MARRIED DIVORCED DIVORCED	B. DATE OF BIRTH 11/23/1905		UNDER 1 YEAR IF UNDER 24 HRS. onths Days Hours Min.
100. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  Retired Farmer	RATMS	Carroll Co	o., Md.	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME  Raymond Stonesifer		Rebecca A		
(Yes, no, or unknown)   (If yes, give war ar dates of service)		nformant s. John Haules	Address r, Westminster,	Md. R. D. 1
Conditions, if any, which gove rise to immediate couse (o), stating the under-lying cause lost.	Aggertense	ular ASE	dent	10 years
TO ACCIDENT MAC IN DECIMAL TO A PORT OF	addid 11	factions	(healed)	IN PART 1(o) 19. WAS AUTOPSY PERFORMED? YES NO
Hour a.m. Whil	6-	ACE OF INJURY (Home, farm, citory, street, affice bldg., etc.		(County) (State
21. I certify that (I) (this haspital) after saw the deceased alive an 22a. SIGNATURE  22c. PHYSICIAN'S NAME (Type)	12 19 61, and that a	M.D. ATTENDING MEPHYS. DIS	M, fram the causes and o	that (I) (we) lass an the date stated above 22b. DATE STONED
23o. BURIAL, CREMATION, REMOVAL (Specify) Burial 6/16/61	23c. NAME OF CEMETERY C	OR CREMATORY  Ley Cemetery	23d. LOCATION (City, town, or co	ounty) (Stote) Md.
24 FUNERAL DIRECTOR'S SIGNATURES	ADDRESS TO TO A			AR'S SIGNATURE

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	policies, and the control of	inoit til.	-perentarian (217m)
Section of the control of	O Weightister, Mi. 8.2.1 C	my rowaled i.	, , , , , , , , , , , , , , , , , , , ,
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	Brown Dr. Dr. C	an alimb	( H877
Standards (M. ed., ex. re	all afficiently account follows		:M.05\0

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MARYLAND	STATE	DEPARTMENT	OF	HEALTH
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MAKILAND STATE DEPARTMENT OF HEALT	In .
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET	BALTIMORE 1, MARYLAN
6680 CERTIFICATE OF DEATH	2.2.2

1. PLACE OF DEATH	2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before edmission)
o. COUNTY Carroll MARYLAND	a. STATE Md. b. COUNTY Carroll
b. CITY OR TOWN (if outside corporete limits,   c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
write RURAL end give neerest town)	Finksburg
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street eddress)	d. STREET ADDRESS   e. IS RESIDENCE
	ON A FARM?
Old Westminster Road	Old Westminster Road YES NO [1]
DECEASED	Last 4. DATE Month Dey Yeer OF
	ullivan DEATH June 1, 1961
7. MAKKIED NEVER MAKKIED	B. DATE OF BIRTH  9. AGE (In yeers   IF UNDER 1 YEAR   IF UNDER 24 HRS.
Female White WIDOWED DIVORCED	March 2, 1907 54 yrs. Months Deys Hours
	RY 11. BIRTHPLACE (County & State, or foreign country)   12. CITIZEN OF WHAT COUNTRY?
Housework	Maryland USA
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Haines	Adalda M. Danis
	Adeline M. Burke
(Yes, no, or unkown) (Ifyesgive weror detes of service)	
	. Charles E. Sullivan Finksburg, Md.
18. CAUSE OF DEATH [Enter only one ceuse per line for (e), (b), end (c).]	INTERVAL BETWEEN ONSET AND DEATH
PART I. DE TH WAS CAUSED BY: Intestinal Heme	orrhage 15 mins.
1533 DUE TO	
Conditions, if a sy, which \ (b) Carcinoma Sigmo	oid Colon layears
geve rise to immediate ceuse	
(e), stating the underlying cause lest.	
	OT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY
E TAKE II. OTHER SIGNIFICANT CONTENTION CONTENTION TO SERVING ON THE	PERFORMED?
V I I I I I I I I I I I I I I I I I I I	YES NO X
OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	D. (Enter neture of injury in Pert I or Pert II of item 18.)
	ACE OF INJURY (Home, farm, 20f. (City or town) (County) (State)
	April 1, 1953 to June 1, 1961, that (I) (we) last
	t death occured a P.P. M, from the causes and on the date stated above.
22e. SIGNATURE	22b. DATE
Martin E. Stubel	A.D. PHYS. MED. STAFF PHYS.   6-2-61
NAME (Type) Martin E. Strobel, M.D.	48 Main Street, Reisterstown, Md.
23e. BURIAL, CREMATION, 23b. DATE THEREOF   23c. NAME OF CEMETERY	
Burial June 5,1961 Finksburg Co	emetery Finksburg, Md.
24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS	250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
J. F. Eline & Sons Reisterstown, Md.	DATE JUN 5 '61 Criting S. Hours
	Louir Matt a

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Martin F. Strebel, M.D. 18 Main Street, Reistansteau, Md.

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The state of the second second

		3, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
FOR STATE	6681 MEDICAL EXAMINER'S	S CERTIFICATE OF DEATH 06665
HEALTH DEPT.	1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
Ssary, Page iles. lealth,	Carroll	Maryland b. COUNTY Montgomery
O I	b. CITY OR TOWN (if outside corporeta limits,   c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (II outside corporata limits, write RURAL end give neerest town)
s necto your	Sykesville 6 days	Monrovia 5X-1
lay is for y Board	d. NAME OF HOSPITAL OR INSTITUTION (il not in hospitel, give streel eddress)	d. STREET ADDRESS   e. IS RESIDENCE
Seral of Control of Co	Springfield State Hospital	RFD #1.Box 207
fun fun aine aine Stat	3. NAME OF First Middle DECEASED	Lasi 4. DATE Month Day Year
If a the rest	(Type or print) ERNEST CARL	TROUT DEATH June 4. 19 61
3 to 3 to affe		DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS.
ma) 2 w urs		lest birthday) Months Days Hours Min.
2, 2 2, 1 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1		11. BIRTHPLACE (State or foreign country)   12. CITIZEN OF WHAT COUNTRY?
as 1, 2s 1, 1 a 1 a 1 7 2	Farm laborer	Maryland U.S.A.
T Fig. 1	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Pw3	Unknown John Andrew Trout	Elsie Burdette
8. Girlihin form 1. Fill	15. WAS DECEASED EYER IN U.S. ARMED FORCES?   16. SOCIAL SECURITY NO. 17.	INFORMANT Address
d w h the f	No No (If yes give we ror defes of services 214-36-0469)	Springfield Hospital Records
Item T with the second of the	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
along transi	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Extensive bilate	eral bronchopneumonia following
be acces a later a lat	888.8 xxxx ingestion of v	vorm seed oil
in pould	Conditions, if eny, which (b)	
shows a show a s	geve rise to immediate cause (e), stating the underlying DUE TO	
andi mine ad a	cause last. (c)	
"pertifi "xan use tion	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO	OT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED?
vord cal I d be	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO	YES X NO
Hediver	E ADULLA DU CI CONTRIBUTION CI	Enter nature of injury in Pert I or Pert It of item 18.)
AEB of N 3 sh urial		orm seed oil
Chic		CE OF INJURY (Home, ferm, 20f. (City or town) (County) (State) ory, street, office bldg., etc.)
A Par 19	71201	in a field   Monrovia Montg. Md.
Pri pri	21. I certify that I took charge of the remains described above, he	eld an Autopsy X. Inspection . Inquiry . and in my opinion
arded RECT	death resulted from: Natural causes, Accident, Suice	ide, Homicide, Undetermined manner 🔀
21 2 S H \	and 1	CHIEF MEDICAL EXAMINER
L to the state of	ACTUAL SIGNATURE	M.D. ASSISTANT MEDICAL EXAMINER DATE SIGNED
PUTY MA	EXAMINER'S	DEPUTY MEDICAL EXAMINER   6/5/61
DEPUTY Ease execute should be for FUNERAL its designate	NAME (Type) Russell S. Fisher, M.D.  22a. BURIAL, CREMATION, 22b. DATE THEREOF   22c. NAME OF CEMETERY OF	Address (Street, city, town, or county)  C CREMATORY   22d. LOCATION (City, town, or country) (State)
	REMOVAL (Specify)	
5 g 4 5 g	Burial June 7,1961 Bethesda	Meth. Browningsville Md.
VS. ATSME	Olin L. Wobsworth Damascus,	Ma ·
5M 9/6D	Town of the local test of	Mil. 8 '61 Ciriling S. Kraus

Items 18-21 Film 290 7 MARYLAND STATE DEPARTMENT OF HEALTH

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TO HOSPITAL OF AT may be retain TO FUNERAL Direct page 3 should be differ englstror prior to

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6682

**CERTIFICATE OF DEATH** 

Reg. Dist. No 6666

1. PLACE (	OF DEATH NTY					2. USUAL RE	SIDENCE (Wh	ere deceased	lived. If institut	tion: Reside	ence befo	re odmiss	sion)
	Carpo			MAR	YLAND	Maryland Carroll							
b. CITY OR TOWN (If outside corporate limits, write RURAL ond give nearest town)					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)								
	kesvil			3 week	cs	F	Rural	Westmi	inster				
OR II	NSTITUTION	AL (If not in hospitol, g	give street	oddress)		d. STREET	ADDRESS					e. IS RES	IDENCE FARM?
Pul	len Nu	rsing Home				B	loute #	7					NO 🔯
3. NAME OF First Middle			Wantzlost		4. DATE OF	Manth		Do	у	Year			
(Type or	r print)	Annie		Estell	la	Want	4	DEATH	Jun	e 25.			1961
5. SEX		6. COLOR OR RACE	7. MARR	RIED NEVER MARRI	IED 🔲	DATE OF BIE	RYH		9. AGE (In years last birthday)	IF UNDE	RIYEAR	IF UND	R 24 HRS.
Fema	le	White	WIDOW	ED CK DIVORCE	ED .	January	12. 1	872	last birthday)		Days	Hours	Min.
10a. USUA	LOCCUPATIO	N (Give kind of work	done 10b.	KIND OF BUSINESS						12. C	ITIZEN O	F WHAT	COUNTRY
during	se work	ng lite, even it retired	,	Own home					Marylan		U.S.		
13. FATHER				OWIT HOME			S MAIDEN N		mary rain	u	0.0.	D. e	
Joh	n N. D	itch							Fronk				
			CES? 16	SOCIAL SECURITY NO	117 18	FORMANT	icy Mar	garec		dress			
ITes, no. or u	nknown) (	f yes, give wor or dates of s	ervice)										
No				None		5. R. E	auline	Zepp.	, R #7,	Westm	inst	er,	Wid.
18. C			use per lir	ne for (a), (b), and (c)	)	, ,	1,-01					ERVAL BE	
	PARI I. DEAL	H WAS CAUSED BY: IMMEDIATE CAUSE (a	un	erwselerde	e h	cest.	deres	a, C	erlen		0111		DEATH
<	120,0	DUE TO	1				Α.				3	h	ena 61
	ditions, if an		, fa	leere, lies	nelu	I pre	way	-, cl	cronic		4	170	
	rise to im (o), stoting to	mediate (	1			1	-					-1	
	couse last.	(c	, ler	su Remo	um	-					12	3 /	one 6
No.	PART II. OTH	ER SIGNIFICANT CON	DITIONS C	ONTRIBUTING TO DE	ATH BUT I	NOT RELATED 1	TO THE TERMIN	NAL DISEASE	CONDITION GI	VEN IN PA	RT 1(a) 1	9. WAS	AUTOPSY
CATION												PERFO	RMED?
	CCIDENT WAS	UNDERLYING	20b. DESC	CRIBE HOW INJURY O	CCURRED	(Enter nature	of injury in P	ort I or Part	II of item 18.1			163	140 []
20o. A	HER, NOTIFY A	UNDERLYING CAUSE OF DEATH				•							
	ME OF INJURY		e 20d IN	NJURY OCCURRED	20e PLA	CE OF INJURY	(Home form	206 (City	as town)		10		
	lour a. n.	19	While	_ Not while	fact	ory, street, offi	ice bldg., etc.)	)	or rownj		(County)		(Stote)
*	p. m.	- 17	at work	at work				10					
21. 1	certify the	t Lattended the	decease	ed fram. 3	m	19 6	L, ta	25 /2	196	_,that I	last sa	w the	decease
alive	on	5 mil	_, 126	21, and that	death	occurred a	12:30	M. fram	the causes				
	-	1/1/	5	31				ADDRESS (Str	eet, city or town,	stote)			WE SIGNED
ACTUA SIGNA	TURE S	toward	6	Hall	A	D	01	-110-	110.	nes	6	26	1
100			- 1		"			Jane -		-1-1			A.34
PHYSIC	(Type) Ho	oward E.	Hall			S	ykesvi	lle, N	Maryland			1	
22o. 8URIA	L, CREMATION	I, 22b. DATE THEREO	F	22c. NAME OF CEM	ETERY OR	CREMATORY		22d. LOCATI	ION (City, town,	or county)		(State	
REMO	val (Specify)	6/27/67		Pleasant					asant Va		Con		•
	DIRECTORS	SIGNATURE . A	1	ADDRESS	V Chalal	ey deme		BY REGISTR		STRAR'S SI			, made
X	onn.	4. skills			Nr.	Eve Free		UL 5	By 240. KEG	JI KAK 3 31	4. 100	aud.	
0.00	Fuss &	SUN		Taneytown	I Will	LyLand	DATE						

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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# MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

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<u> </u>	0.003
	PLACE OF DEATH a. COUNTY  Carroll  MARYLAND  2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY  CARROLL  MARYLAND
	b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town)  Russ - Charles of the corporate limits, write RURAL and give nearest town)
	d. NAME OF HOSPITAL (If not in hospital, give street address)  OR INSTITUTION  d. STREET ADDRESS  Mineral Hill Road  ON A FARM?  YES \( \sum NO)  NO. STREET ADDRESS  YES \( \sum NO)  NO. STREET ADDRESS  ON A FARM?  YES \( \sum NO)  NO. STREET ADDRESS  ON A FARM?  YES \( \sum NO)  NO. STREET ADDRESS  ON A FARM?  YES \( \sum NO)  NO. STREET ADDRESS  ON A FARM?  YES \( \sum NO)  NO. STREET ADDRESS  ON A FARM?  YES \( \sum NO)  NO. STREET ADDRESS  ON A FARM?  YES \( \sum NO)  NO. STREET ADDRESS  ON A FARM?  YES \( \sum NO)  NO. STREET ADDRESS  ON A FARM?  YES \( \sum NO)  NO. STREET ADDRESS  ON A FARM?  YES \( \sum NO)  NO. STREET ADDRESS  ON A FARM?  YES \( \sum NO)  NO. STREET ADDRESS  ON A FARM?  YES \( \sum NO)  NO. STREET ADDRESS  ON A FARM?
	NAME OF DECEASED (Type or print) JOHN HENRY WILLIAMS 4. DATE OF DEATH JUNE 10 1961
3	SEX    6. COLOR OR RACE   7. MARRIED   NEVER MARRIED   B. DATE OF BIRTH    Male   WIDOWED   DIVORCED   After 25, 1874   9. AGE (In years last birthday)   Wonths Days Hours Min.
	D. USUAL OCCUPATION (Give kind of wark dane)  10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country)  12. CITIZEN OF WHAT COUNTRY?  Charles Country  12. CITIZEN OF WHAT COUNTRY?
	THERE'S NAME T. Williams 11. MOTHER'S MAIDEN NAME MANYA J. THOMEN
15. (Ye	WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT s. no. or unknown) (If yes, give wor or dates of service) 2/9-03-4026 Ms John W. Williams Orghisolle, Md.
	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a)  DUE TO  Conditions, if any, which)  (b)  ALLAND ALL
	gave rise to immediate cause (a), stating the under- lying cause last.  DUE TO  Cause Inst.  DUE TO  Colorana C
CATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. MAS AUTOPSY PERFORMED?  YES \( \sigma \text{NO} \sigma \)
L CERTIFI	20a. ACCIDENT WAS UNDERLYING  CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
MEDICAL	20c. TIME OF INJURY Month, Day, Year Haur a. m.  p. m.  19  20d. INJURY OCCURRED While Nat while at wark at wa
	21. I certify that (I) (this hospital attended the deceased fram. 19 1, ta 10 1, that (I) (we) last saw the deceased alive an 10 1, and that death accurred at 200, from the causes and on the date stated above.
	220. SIGNATURE  M.D. ATTENDING MED. DIRECTOR STAFF SIGNED PHYS. DIRECTOR PHYS.   10 June 61
	PAME (Type) HOWARD E. HALL SYITESVILLE, MD.
1	23c. NAME OF CEMETERY OR CREMETORY 23d. LOCATION (City, town, or county) (State)
24.	FUNERAL DIRECTOR'S SIGNATURE SADDRESS 250. REC'D'BY REGISTRAR 256. REGISTRAR'S SIGNATURE  LATER OF THE STATE

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral directar, page 3 shauld be detached far use as the burial-transit permit. Then please remave carban papers. Pages 1 and 2 shauld be filed with the State Board of Health prior to burial, cremation, ar remaval, and in any event, within 72 haurs after death. nin 24 haurs after NDING PHYSICIAN: The law requires that the death certificate be execute TO HOSPITAL

VR A15 (4) 15M 9/59

